C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

September 30, 2010

Tom Moss, Administrator Preferred Community Homes - Courtyard 615 Second Avenue West Wendell, ID 83355

Provider #13G057

Dear Mr. Moss:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004710

Allegation #1: Individuals are not receiving active treatment, including physical therapy exercises, due to insufficient numbers of staff.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 6 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 4 hours and 6 minutes across the morning and evening shifts. During that time, 4 direct care staff were noted to be working each of those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 3 individuals were selected for review. The individuals' records documented ongoing

Tom Moss, Administrator September 30, 2010 Page 2 of 4

program implementation at the assigned rates.

Further, 10 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals who require one-to-one supervision are not one-to-one due to insufficient numbers of staff.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 6 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals. The Administrator stated 2 of the individuals required one-to-one supervision due to maladaptive behaviors.

Observations were conducted for a cumulative 4 hours and 6 minutes across the morning and evening shifts. During that time, 4 direct care staff were noted to be working each of those shifts. Two individuals were noted to be staffed one-to-one. The remaining 2 staff were noted to work with the other 4 individuals. Staffing was maintained for all individuals residing in the facility.

Further, 10 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Inappropriate behavioral interventions are being used by staff.

Finding #3: An unannounced on-site complaint investigation was conducted on 9/13/10 -

Tom Moss, Administrator September 30, 2010 Page 3 of 4

9/16/10. During that time, incident/accident report review, investigation review, observations, record review, and staff interviews were completed with the following results:

Incident/accident reports and investigations were reviewed from 7/1/10 - 9/13/10. None of those documents showed inappropriate behavioral interventions were used.

Further, observations were conducted on 9/14/10 for a cumulative 4 hours and 6 minutes. During that time, no inappropriate behavioral interventions were noted to be used with any individuals. Additionally, 10 direct care staff were interviewed during the course of the survey. None of those staff reported inappropriate use of behavioral interventions.

However, the incident/accident reports documented that an individual who engaged in self abuse and required a helmet to protect him, continued to sustain ongoing head injuries because his helmet was not used.

Additionally, during the above noted observations, the individual who required the use of a helmet to protect him from self abuse was noted to be one-to-one with staff. When interviewed, the staff working with the individual reported they had not been trained on the individual's behavioral interventions. An additional staff was interviewed on 9/15/10 at 11:45 a.m. That staff reported she worked one-to-one with the individual and had not been trained on the individual's behavioral interventions.

Three individuals' records were selected for review. One of those records showed the behavior intervention plan for the individual who required the helmet was not sufficiently developed to identify how the helmet could be easily accessed when the individual engaged in self abuse.

Therefore, the allegation was unsubstantiated. However, deficient practice was identified and the facility was cited at W127, W193, W249, and W285.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A staff person working at the facility does not have legal rights to work in this country.

Finding #4: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, interview with the Administrator was conducted with the following results:

Tom Moss, Administrator September 30, 2010 Page 4 of 4

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported the corporate office had received a complaint alleging a staff person working in the facility did not meet legal requirements to do so. The Administrator reported all personnel records were reviewed and found to be in compliance with legal requirements for employment.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Sicharl C. Case, LEW

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE

Health Facility Surveyor

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

MC/srm

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0864

September 30, 2010

Tom Moss, Administrator Preferred Community Homes - Courtyard 615 Second Avenue West Wendell, ID 83355

RE: Preferred Community Homes - Courtyard, Provider #13G057

Dear Mr. Moss:

Based on the complaint survey completed at Preferred Community Homes - Courtyard on September 16, 2010, by our staff, we have determined that Preferred Community Homes - Courtyard is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Conditions of Participation for Client Protections (42 CFR 483.420); Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Courtyard to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before October 31, 2010. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than October 20, 2010.

The following is an explanation of a credible allegation:

Tom Moss, Administrator September 30, 2010 Page 2 of 3

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of <u>IDAPA 16.03.11.320.04</u>, Preferred Community Homes - Courtyard ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective September 16, 2010, through January 14, 2011. The conditions of the Provisional License are as follows:

- 1. Post the provisional license.
- 2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **October 27, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Tom Moss, Administrator September 30, 2010 Page 3 of 3

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator Division of Medicaid -- DHW PO Box 83720 Boise, ID 83720-0036 Phone: (208)364-1804

Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by October 12, 2010. If a request for informal dispute resolution is received after October 12, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

MICHAEL CASE

Health Facility Surveyor

NSicharl Case, LSD

Non-Long Term Care

NICOLE WISENOR

Musikal Wilser

Co-Supervisor

Non-Long Term Care

MC/srm Enclosures October 12, 2010

RECEIVED

OCT 2 0 2010

Nicole Wisenor, Co-Supervisor, Non-Long Term Care Idaho Department of Health and Welfare Bureau of Facility Standards PO Box 83720 Boise, ID 83720

FACILITY STANDARDS

Dear Ms. Wisenor:

Preferred Community Homes – Courtyard alleges compliance with the Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions of Participation on Client Protections, and Client Behavior & Facility Practices.

Preferred Community Homes has accomplished the following in preparation for a revisit:

- The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained.
- Preferred Community Homes has hired a new Administrator that is assigned to the Twin Falls/Wendell area. She has worked with individuals with disabilities since 1993. She has managed staff in group home settings and is a LMSW and has a bachelor's degree in Special Education.
- The supervisor at the Courtyard home has been relieved of her supervisory duties at the other facilities. She is now full time at the Courtyard home. She is expected to work at least two shifts per week on the floor with her staff to provide oversight and training for them.
- Preferred Community Homes has sent experienced QIDP's to the Wendell area to
 assist with assessment and program revisions. An IPP was held for each
 individual living in the Courtyard home. Included in the revisions are the
 Behavior Assessments, Behavior Management Plans as well as the Medication
 Reduction Plans. Through this process they are teaching the AQIDP in Wendell
 the appropriate methods for addressing the behavioral needs of the individuals.
 The IPP's will be completed and implemented by 10/20/10.
- The Individuals that are utilizing behavior modification medications are currently being brought to the Psych Clinic at the corporate office instead of a private

physician. This way changes can be monitored and input can be taken from all team members prior to a medication being implemented.

- As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy: An addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his Addendum has worked with him. By 9/26/10 all the staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. As a result several additional revisions have been made to Individual #1's BIP since the survey team exited the facility.
- All staff in the home are currently being re-trained in regards to all of the revised BIP's. This training will be completed no later than 10/20/10.

If you have any further questions, please feel free to contact me at 208-855-9142

Tom Moss

PCH-Courtyard, Acting Administrator

PRINTED: 09/29/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The following def complaint survey The survey was of Michael Case, LS Monica Nielsen, Common abbrev report are: ADHD - Attention ADL - Activities of AQMRP - Assista Professional BIP - Behavior In IDT - Interdiscipli IPP - Individual FLPN - Licensed FMAR - Medication OCD - Obsessive OSHA - Occupal Mandt - A physic RN - Registered RSC - Residentia QMRP - Qualifie Professional 483,420 CLIENT The facility must protections required.	conducted by: SW, QMRP, Team Leader QMRP diations/symbols used in this Deficit Hyperactivity Disorder of Daily Living ant Qualified Mental Retardation revention Program nary Team Program Plan Practical Nurse on Administration Record of Compulsive Disorder ion Safety Health Association al restraint system Nurse of Service Coordinator of Mental Retardation PROTECTIONS ensure that specific client rements are met.	W 122	"Preparation and implementa plan of correction does not consist admission or agreement by C with the facts, findings or oth statements as alleged by the agency dated September 16, Submission of this plan of consequired by law and does not the truth of any or some of the as stated by the survey agency Courtyard – Preferred Comment Homes, specifically reserves move to strike or exclude this as evidence in any civil, crimal administrative action."	ction of this constitute courtyard her state 2010. For exidence he findings by hunity the right to s document hinal or CEIVED TY STANDARDS lates to the at d consent
I A B O B A T C	Based on observe policies and processory client	vations, review of the facility's bedures, incident/accident eview, and staff interviews it was acility failed to provide the protections and ensure steps	NATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	abuse. These failureffective systems to being subjected to head injuries and commediate jeopardy individual. The find 1. Refer to W124 at failure to ensure and consent for restrictive 2. Refer to W127 at failure to ensure and to ongoing self abut 3. Refer to W249 at failure to ensure and implemented and failure to ensure a	act an individual from self res resulted in a lack of prevent an individual from self abuse resulting in ongoing onstituted serious and y to the health and safety of an lings include: s it relates to the facility's individual's written informed we interventions was accurate. s it relates to the facility's individual was not subjected se. s it relates to the facility's individual's behavior plan was collowed as written. of ECTION OF CLIENTS assure the rights of all clients. ty must inform each client, is a minor), or legal guardian, cal condition, developmental itus, attendant risks of the right to refuse treatment. is not met as evidenced by: eview and staff interviews, it er facility failed to ensure	W 122	Please refer to W127 as it relate facility's failure to ensure an income was not subjected to ongoing see. Please refer to W249 as it relate facilities failure to ensure an individual's behavior plan was implemented and followed as with the without and followed as with the	ction ct	

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W 124	1. Individual #3's year old male who profound mental respectively individual #3's Phenomental respectively individual #3's Phenomental respectively individual #3's Windividual #3's Windividual #3's Windividual #3's Phenomental respectively individual #3's Windividual #3's Wind	dividual's guardian regarding intions. The findings include: 2/16/10 IPP stated he was a 12 ose diagnoses included retardation, ADHD, and autism. Sysician's Order, dated 8/10, eceived Risperidone (an angle) 3 mg each evening and sychotic drug) 80 mg each each each each each each each each	W 124	Administrative staff includin importance of assuring adequinformation is included in the informed consents. The Assistant to the Regiona Administrator has been assig provide supervision to the Colley ICF/MR. He will spend a mifour days per month in the Wiccompleting Quality Assurance to assure that compliance wiregulations is maintained. Of the Quality Assurance measure includes review of the writte consents to verify that sufficinformation is included with consents so the guardian can informed treatment decisions event that it is discovered the informed consent does not he sufficient information including immediate training will be puthe QMRP and corrections with the QMRP and corrections with the Quality Assurance Proce be assisting with Quality Assurance Proce be assisting with Quality Assurances. Person Responsible: Tom Massistant to the Regional Ada Completion Date: 10/20/10	Interest of intere	

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W 124	maladaptive behave step direction for Ginformation about the drugs, it would not guardian to make at their use. During an interview p.m., the Administration QMRP, stated he creason Individual #Geodon. The Administration were for maladaptic behaviors were not the consents. The thing that was according to the consents.	ridone and undefined riors versus following a one secondon). Without clear the intended outcome of the be possible for Individual #3's an informed decision regarding on 9/16/10 from 1:05 - 1:50 rator, who was also the Acting did not know the specific 3 was receiving Risperidone or ninistrator stated the drugs we behaviors, but the specific to clear and were not defined in Administrator stated the only urate in Individual #3's Written is was the information related to	W	124			
W 127	Informed Consents contained sufficier make informed tre 483.420(a)(5) PRORIGHTS The facility must e Therefore, the facility must e psychological abuse. This STANDARD Based on observal interviews, it was densure an individual self abuse for 1 of	nsure the rights of all clients. lity must ensure that clients are invisical, verbal, sexual or	W	127	W 127 483.420(a)(5) PROTE OF CLIENTS RIGHTS As stated in the report the follo actions were taken on 9/15/10 the immediate jeopardy: An addendum to the BIP was swhich gave specific guidelines individual #1's helmet use, use pillow and clear indicators relaindividual #1's escalation. Sin 9/15/10 Preferred Community has assured that only MANDT and staff trained in his Addend worked with him. By 9/26/10	owing to abate submitted for of a ated to ace Homes certified lum has	

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	"[Individual #1] will with one to one stawaking hours" He behaviors included as biting self, hitting His BIP stated if he agitated (defined a face), staff were to (Happy, Sad, and feeling card that be feeling. If he atternelmet was to be	, dated 3/12/10, stated remain safe by being provided affing within arm's length, during his BIP stated his maladaptive is self abuse which was defined in self, and head banging. The showed signs of becoming a getting an angry look on his o show him the feeling cards (Angry) and have him pick a lest described how he was appeted to bang his head, his used for up to two minutes at a him safe from injury.			The Assistant to the Regional Administrator has been assigne provide supervision to the Cour ICF/MR. He will spend a minifour days per month in the Wer completing Quality Assurance to assure that compliance with regulations in maintained. One the Quality Assurance measure includes reviewing Incident and Accident reports and doing obs to assure that each consumer w facility is safe. In the event that concern is identified, the Assist the Regional Administrator has given the instruction to take im	mum of mum of mum of measures e part of s d ervations ithin the at a safety tant to s been	

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	this happened bef Behavior Slip show hand blocking wer	t was not documented whether fore or after the fall. Further, the wed only verbal cues and open re used; it was documented that and helmet were not used as per					

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	hit his head on the injury" resulting in a to the report, a teal	n.: Individual #1 dropped and floor. He "reopened head a ½ inch abrasion. According m meeting was to be held "to a alternative things to do."					
	7/7/10, showed he times. Further, the cues, open hand b were used; it was o	esponding Behavior Slip, dated hit his head on the floor 2 Behavior Slip showed verbal locking, and body positioning documented that his feeling were not used as per his BIP.					
	the front door. Wh down on the sidew cement. He "reope	m.: Individual #1 "darted" out en staff blocked him, he sat alk and hit his head on the ened cut on forehead" resulting on to his upper middle					
	7/12/10, showed he times. Further, the cues and body pos	esponding Behavior Slip, dated e hit his head on the floor 2 e Behavior Slip showed verbal sitioning were used; it was his feeling cards and helmet her his BIP.					
		n.: Individual #1 hit the back of all and on the kitchen floor. No s sustained.					
	8/2/10, showed he times, and hit his he Further, the Behav	esponding Behavior Slip, dated hit his head on the wall 2 head on the floor 3 times. rior Slip documented "no" next to whether his BIP was	-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLI .DING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WIN			1	C 6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP COD SECOND AVENUE WEST NDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 127	on the living room injury. According to Investigation Reporecently met and in provide him with our remain safe while. However, the corres 8/22/10, stated he "no" next to the quivas followed as with a safe with	m.: Individual #1 hit his head wall. There was no apparent of the corresponding of "[Individual #1's] team has nade the decision to continue to the to one staffing to help him in his environment." esponding Behavior Slip, dated hit his head and documented estion as to whether his BIP ritten. m.: Individual #1 was blocked to the hit his head on the dining g in a ½ inch abrasion with a 1	W 1	27			
		m.: Individual #1 "got out the		- V > V + V + V + V + V + V + V + V + V +			

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 09/29/2010 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDIN	NG	COMPLE	TED
		13G057	B. WI	1G _		1	C 6/2010
	ROVIDER OR SUPPLIER RED COMMUNITY HO	DMES - COURTYARD	<u>'</u>	6	REET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 127	gate" [sic] and hit hidriveway. He "oper resulting in an "abra diameter." There was no corre - 9/2/10 from 2:00 - "banged his head oresulting in "anothe lump 2 [inches] diar fluid filled." Individual hospital for evaluation However, there were Behavior Slips, date following: - At 2:00 p.m.: He hitmes; it was docum question as to whele written. - At 2:30 p.m.: He hitmes; it was docum question as to whele written. - At 3:30 p.m.: He hit was docum question as to whele written. - At 3:30 p.m.: He hit was documented whether his BIP was documented whether his BIP was according to an Inv 9/2/10, Individual # have his head injury corresponding Head (20 minutes on and	is head on the concrete hed scabbed forehead" ased [sic] area now 1 inch in the sidewalk and on the dirt" or ½ cm abrasion to forehead, meter mushy poss (possibly) all #1 was taken to the ion. The three corresponding and 9/2/10, which showed the ased 9/2/10, which showed the ased in this head on the ground 2 mented "no" next to the inther his BIP was followed as ased in this head on the table 1 time; "no" next to the question as to showed as written. The stigation Report, dated 1 was taken to the hospital to y assessed. The assessed ith Status Report showed ice 20 minutes off), Tylenol (assessed).	W	127			
		c drug) 650 mg that evening ving morning, and monitoring es, sleepiness and					

(X2) MULTIPLE CONSTRUCTION

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION	(X3) DATE S COMPLI	ETED
		13G057	B. WIN	IG			C 6/2010
	PROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	(X5) COMPLETION DATE
W 127	disorientation were - 9/4/10 at 5:30 p.r and "banged his had there were no approposed to the corresponding stated he hit his he documented "no" whether his BIP was a stated he hit his he documented "no" whether his BIP was a stated he hit his he documented "no" whether his BIP was a stated he hit his he documented "no" whether his BIP was a stated whether his BIP was a stated with a stated where the had stated where the had RSC both stated where the had RSC both stated what staff was a sked when he had required in other lanswer. Individual #1 required supervision and a injuries when he had required in the had required in other lanswer.	e ordered. m.: Individual #1 ran outside ead on the grass 5 times." parent injuries. g Behavior Slip, dated 9/4/10, ead on the grass 5 times and next to the question as to as followed as written. m.: Individual #1 "went in to a f stopped him from going to the ground" and hit his head in floor. He "reopened the cut According to the Nursing of the report, he sustained a "1/4"	W	127			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL ILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII	NG			C 1 6/2010
				615	ET ADDRESS, CITY, STATE, ZIP COD SECOND AVENUE WEST ENDELL, ID 83355	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 127	documentation shall be access of his staff developed to includ locality of the helr showed his BIP was written. b. During an obseted individual #1 walk noted he had two middle of his fore 1/2 inches of slight the scabs. Individual #1 walk noted he had two middle of his fore 1/2 inches of slight the scabs. Individual #1 person was a full-faced in where the helmet stated it was usual bedroom or on to the living room, be earlier that morning their person at all Individual #1 requon the helmet as before it was on. snug." On 9/14/10 at 2:4 informed by the Athe fitting of Individual #1's he Individual #1's he Individual #1's he Individual #1's he	loage 10 showed his helmet was not used. The was not kept within easy of and his BIP was not sufficiently used directions to staff about the met. Additionally, documentation was not implemented or followed ervation on 9/14/10 at 7:26 a.m., seed into the kitchen and it was small eraser-sized scabs on the head with approximately 1 and ally raised scar tissue surrounding dual #1 was asked about his ed to show it to the survey team. Working with Individual #1 she was carrying. The helmet motocross helmet. When asked was usually kept, the staff ally kept in Individual #1's pof the entertainment center in ut they were told by the AQMRP and that staff should keep it on times. It was noted that uired assistance from staff to put it required two downward tugs. Staff reported it was "a little staff reported it was "a little staff and was too small.	W	127			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPL ILDING	E CONSTRUCTION	(X3) DATE S COMPLI	ETED	
		13G057	B. WI	NG			C 6/2010	
	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355	'		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 127	at 2:55 p.m., the sign individual #1 was a reported it was her Individual #1. Who stated she did not head banged his head, individual #1 for 2 staff person report it was noted she her person. The Administrator assignments on 9/the RSC made the was present, was making staffing as not use any criteria she "just rotate stated was present, was individual #1 nor hor backpack. The about her training, with Individual #1 nor hor backpack. The about her training, with Individual #1's BIP and tried to keep hehaviors consisted banging, and biting his head, she blood she thought he halp his bedroom and "staff stated that if they were to tell his on the helmet. The	vation at the facility on 9/14/10 taff person assigned to asked about her training. She first time working with an asked about his BIP, she know the plan but believed he cried. She reported if he they were to put the helmet on minutes. When asked, the ed she was not Mandt certified. ad Individual #1's backpack on was interviewed about staffing 14/10 at 3:40 p.m. He reported assignments. The RSC, who asked about criteria used when signments. She stated she did a to make decisions; she stated	W	127				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G057	B. WING			C 09/16/2010	
	PROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	EX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
W 127	direct care staff we Staff assigned to Ir sufficiently trained appropriately intervabuse. Further, the training or knowled making staff assign d. Review of Individently 7/1/10 - 9/7/10, cor BIP was not being asked, the AQMRF p.m., she was awa Individual #1's BIP written and his help followed, he would The QMRP reported did not document to Individual #1's BIP followed as written the issue. However evidence that the Cothe issue. In sum, Individual #1 is BIP followed as written the issue. In sum, Individual #1 is BIP followed as written the issue. In sum, Individual #1 is BIP followed as written the issue. In sum, Individual #1 is believed to sustain his helmet was not not fit him approprike the with his staff platicular #1 were	andividual #1 were not on his BIP such that they could were and protect him from self e RSC did not consider staffs' lige of Individual #1's BIP when naments. Idual #1's Behavior Slips, dated nationed documentation that his implemented as written. When e stated on 9/15/10 at 12:45 re the documentation showed was not being implemented as met was not being used. IMRP stated on 9/15/10 at noted in the documentation BIP was not implemented or have called a team meeting.	W	127			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		13G057	B. WING			C 09/16/2010	
	ROVIDER OR SUPPLIER	HOMES - COURTYARD	s	TREET ADDRESS, CITY, STATE, ZIP CO 615 SECOND AVENUE WEST WENDELL, ID 83355			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 127	followed as writte action was not tal cumulative effect placed Individual the potential for himpairment or deal Note: On 9/15/10 submitted an imm 9/15/10, which she for Individual #1's helmet use, use dindicators related The Plan stated a would be Mandt diaddendum before that all staff would the Plan stated of by management is morning and once Individual #1's Blick a weekly behavior to evaluate Individual #1's Blick a weekly behaviore to evaluate Individual #1's Blick a weekly behaviore to evaluate Individual #1's Blick a weekly behaviore to evaluate Individual #1's Blick as weekly	BIP was not implemented or and appropriate corrective sen to resolve the issue. The of these deficient practices #1 in immediate jeopardy due to im to sustain serious harm, ath, caused by self injury. at 5:50 p.m., the facility nediate Plan of Correction, dated owed an addendum was written BIP that included appropriate of the safety pillow, and clear to Individual #1's escalation. Ill staff working with Individual #1 sertified and trained on the working with Individual #1, and is be trained by 9/26/10. Further, oservations would be conducted staff, at least once in the ein the evening, to ensure P was followed. The Plan stated in meeting would occur in order dual #1's data and incident ions to his BIP, if necessary, ations and staff interviews ening of 9/15/10 and the 0, it was determined the	W 12		be provided regards to al possessions		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G057	B. WI	1G			6/ 2010
	PROVIDER OR SUPPLIER RED COMMUNITY HO	DMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 137	was determined the sufficient systems in implemented to enspossessions were a 5 of 6 individuals (I #6) whose Personal That failure had the individuals (Individuals (Individuals (Individuals) posses destroyed without a implemented. The Individuals #1 - #6s were reviewed on 9 full inventory needs September and De However, when as stated on 9/15/10 funct know how frequencemented. A review of the form had not been completed. A review of the form had not been completed. Individual #1's Percompleted on 9/8/0 - Individual #2's Percompleted on 5/4/0 - Individual #5's Percompleted on 9/10 - Individual #6's Percompleted on 9/18, completed	wiew and staff interviews, it is facility failed to ensure and been developed and sure individuals' personal accounted for and secured for individuals #1, #2, #3, #5 and all Inventories were reviewed. It is potential to impact all uals #1 - #6) residing in the ed in the potential for sions to be lost, stolen, or appropriate interventions being findings include: If Personal Inventory forms 8/15/10. The forms stated "A is to be done in March, May, cember for every client." If we about the forms, the RSC from 6:20 - 6:50 p.m., she did uently the forms were to be and documented full inventories pleted as required, as follows: If you have to be a solution of the property was last and the potential inventory was last and the potential to ensure the pote	W	137	A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrator receive training from current Administrative staff including a importance of assuring that per possessions are accurately according and kept secure. The Assistant to the Regional Administrator has been assigned provide supervision to the Counterford Counterford Quality Assurance to assure that compliance with regulations in maintained. One the Quality Assurance measure includes reviewing that personal possessions are inventoried and safe. After the program Administrator has displayed a clear understant the Quality Assurance Process, be assisting with Quality Assurance Process, be assisting with Quality Assurance Responsible: Tom Mo Assistant to the Regional Administrator Date: 10/20/10	the ay will be attor will the sonal bunted to rtyard imum of indell area measures a part of estal likept instrator ding of a she will rance	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SU COMPLE	
		13G057	B. WIN	IG			C 6/2010
	ROVIDER OR SUPPLIER	HOMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 137	various clothing it discarded since to completed. How documentation of items. When asked durification of the completed during the completed during the currently be possible taking individuals. The Administrator interview, stated ensuring Personal completed quarter Administrator stated to ensure individuals.	obage 15 6 were reviewed and showed terms had been added and the full inventories were ever, there was no fix what happened to discarded and the RSC stated staff would bag or torn clothing for disposal or torn clothing for to complete sonal inventory form to ms removed. The RSC stated that items had been removed by the RSC stated it would not lible to ensure staff were not belongings for their own use. In who was present during the the RSC was responsible for all inventory forms were the RSC was responsible for the library forms were the the facility would be unable unals' belongings were accounted with the current implementation	W	137			
W 159	possessions werkept secure. 483.430(a) QUAI RETARDATION Each client's actiontegrated, coord	to ensure individuals' personal e accurately accounted for and LIFIED MENTAL PROFESSIONAL ve treatment program must be inated and monitored by a retardation professional.	W	159	W 159 483.430(a) QUALIFII MENTAL RETARDATION PROFESSIONAL A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first day 10/13/10. The new Administrator was a supplemental to the courty and the courty and the courty ard Facility.	as been he ay will be	
		is not met as evidenced by: ations, review of the facility's			receive training from current Administrative staff including		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
_		13G057	B. WING			C 09/16/2010	
	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
W 159	reports, record revidetermined the facing provided sufficient which directly important (Individuals #1 - #6) residing in resulted in individuals sessments, train meet their behavior include: 1. Individual #1's ERSC, AQMRP, and track all behaviors discuss behaviors progress notes. When asked for the on 9/15/10 at 12:4 completed for any 2. Refer to W124 failure to ensure the individual's written restrictive intervental and subjected. 3. Refer to W127 failure to ensure the was not subjected. 4. Refer to W137 afailure to ensure the personal possession.	dures, accident/incident iew, and staff interviews it was bility failed to ensure the QMRP monitoring and coordination acted 3 of 3 individuals 3 reviewed, and had the 6 of 6 individuals (Individuals at the facility. That failure reals not receiving the necessary ning, and monitoring required to real needs. The findings BIP, dated 3/12/10, stated the did QMRP were to monitor and throughout the workweek and on the monthly AQMRP The notes, the AQMRP reported 5 p.m., notes had not been individuals since 6/10. The individuals since 6/10 individuals since 6/10 informed consents for tions were accurate. The it relates to the facility's are QMRP ensured an individual to ongoing self abuse. The it relates to the facility's are QMRP ensured individuals in the individuals' ons were accounted for. The it relates the facility's failure are quite to staff demonstrated consistently implement an		159	importance of assuring that all notes are kept up to date as speach BIP. The Assistant to the Regional Administrator has been assign provide supervision to the Colley MR. He will spend a mirrour days per month in the We completing Quality Assurance to assure that compliance with regulations in maintained. On the Quality Assurance measurincludes reviewing that prograreviewed and revised as necessiven for W124, W127, W137, W207, W214, W227, W237, W249, W260, W278, W285, W312 and W313. Person Responsible: Tom Massistant to the Regional Admic Completion Date: 10/20/10	ned to urtyard nimum of endell area e measures nee part of ees am data is esary. ction 7, W193, W239, W289,	

A. BUILDING	
I B WING	C 6/2010
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159 Continued From page 17 individual's Behavior Intervention Program. 6. Refer to W207 as it relates to the facility's failure to ensure the QMRP ensured appropriate facility staff participated in interdisciplinary team meetings. 7. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 8. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured behavioral objectives were developed to address an individual's maladaptive behaviors. 9. Refer to W237 as it relates to the facility's failure to ensure the QMRP ensured data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 10. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured the replacement plans for individuals' maladaptive behavior was developed to meet their behavioral needs. 11. Refer to W249 as it relates to the facility's failure to ensure the QMRP ensured an individual's behavior plan was implemented as written. 12. Refer to W260 as it relates to the facility's failure to ensure the QMRP ensured individuals' IPPs were revised as necessary. 13. Refer to W278 as it relates to the facility's failure to ensure the QMRP ensured less	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	COMPLE	TED
		13G057	B. WIN	IG		1	C 6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355	90, (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	restrictive intervent and proven to be in restrictive intervent. 14. Refer to W285 failure to ensure the techniques to many were employed with supervision to ensure welfare and civil ar protected. 15. Refer to W289 failure to ensure the techniques used to behavior were incorplans. 16. Refer to W312 failure to ensure the modifying drugs were comprehensive parts was directed specific.	ions were systematically tried reffective prior to implementing ions. as it relates to the facility's e QMRP ensured that age inappropriate behavior h sufficient safeguards and ire and individual's safety, and human rights were as it relates to the facility's e QMRP ensured that manage inappropriate rporated into the program as it relates to the facility's e QMRP ensured behavior ere used only as a rt of an individual's IPP that fically towards the reduction of nation of the behaviors for	W	159			
W 193	failure to ensure the modifying drugs we of the behavior was associated risks of 483.430(e)(3) STA Staff must be able techniques necess to manage the inar	FF TRAINING PROGRAM to demonstrate the skills and ary to administer interventions oppropriate behavior of clients.	W	193	W 193 483.430(e)(3) STAFF TRAINING PROGRAM Preferred Community Homes h assessed the number of supervisus assigned to each facility. The Courtyard facility currently has supervisor specifically assigned	sors	
	INISSTANDARD	is not met as evidenced by:			supervisor specificanty assigned	only to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WING		C 09/16/2010	
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 315 SECOND AVENUE WEST WENDELL, ID 83355	03/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION	
W 193	interviews it was de ensure staff demon competencies to ac 2 individuals (Indivi intervention progra in staff being insuff individual's self abut 1. Individual #1's IF a 21 year old male mental retardation, disorder, and autist His BIP, dated 3/12 remain safe by bein staffing within armithours" His BIP stated his refusing to listen and dropping to the flood (defined as hitting, kicking, shoving, and (defined as biting shanging) and elope facility without staff. His BIP stated if he his helmet was to be at a time to help keep and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot) and/or a 2 person versus and the somewhere that was road or parking lot).	ion, record review, and staff etermined the facility failed to estrated the skills and dminister interventions for 1 of dual #1) whose behavior in was reviewed. This resulted iciently trained to address an ise. The findings include: P, dated 3/12/10, documented diagnosed with moderate pervasive developmental icic and OCD traits. P/10, stated "[Individual #1] willing provided with one to one is length, during waking maladaptive behaviors ative behavior (defined as and follow directions and or), physical aggression biting, pinching, scratching, and head butting) self abuse elf, hitting self, and head ement (defined as leaving the	W 193	it. The supervisor is assigned to two shifts per week on the floor the direct care staff. With a suppassigned to the home, the staff with the home will receive more train oversight. As stated in the report the follow actions were taken on 9/15/10 to the immediate jeopardy: Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's he use, use of a pillow and clear increlated to individual #1's escalated Since 9/15/10 Preferred Community Homes has assured that only Maccertified and staff trained in his Addendum has worked with him 9/26/10 all the staffs allowed to with individual #1 were trained BIP. There were some staff that not MANDT certified and other were hired after this that were not allowed to work with him. Prefice Community Homes has conduct observations on the AM and PM since 9/15/10 to assure that the I been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred discuss individual #1's needs. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first day 10/13/10. The new Administrat receive training from current Administrative staff including the importance of assuring that all simportance of assuring that all simportan	with ervisor vithin sing and ving abate elmet dicators tion. mity ANDT n. By work on his t were s that ot erred ded I shifts BIP has nunity d to s been e y will be or will ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	13G057	B. Wit	1G			C 1 6/2010
	OMES - COURTYARD	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Individual #1's Inc Behavior Slips, da showed he continu from hitting his he implemented as w During an observa Individual #1's one Individual #1's hel usually kept in Individual #1's help were to be the was her first time was her first time was her first time when asked about not know the plan and cried. She rethey were to put the minutes. When a she was not Mano had Individual #1's	ident/Accident Reports and ted 1/5/10 and 7/10 - 9/7/10, used to sustain head injuries ad and his BIP was not written. ation on 9/14/10 at 7:26 a.m., as-to-one staff was asked about met. The staff stated it was ividual #1's bedroom or on top ent center in the living room, but the AQMRP earlier that morning eep it on their person at all ation at the facility on 9/14/10 at f person assigned to Individual the training. She reported it working with Individual #1. It his BIP, she stated she did but believed he head banged ported if he banged his head, he helmet on Individual #1 for 2 sked, the staff person reported it certified. It was noted she is backpack on her person.	W	193	receives training and oversiglable to provide optimal care. The Assistant to the Regional Administrator has been assign provide supervision to the Collection of the Completing Quality Assurance to assure that compliance with regulations is maintained. On the Quality Assurance measure includes reviewing staff train and talking with staff about the training to verify that staff readequate training. After the part of the Quality Process, she will be assisting Quality Assurance measures. Person Responsible: Tom Measurement of the	ned to ourtyard nimum of endell area e measures h ne part of res ing records neir ceives orogram a clear Assurance with	
assignments on 9 the RSC made the was present, was making staffing as not use any criteri she "just rotate state". On 9/15/10 at 11:2	/14/10 at 3:40 p.m. He reported assignments. The RSC, who asked about criteria used when ssignments. She stated she did a to make decisions; she stated aff."					
	RRED COMMUNITY H SUMMARY ST (EACH DEFICIENCE REGULATORY OR Individual #1's Inc. Behavior Slips, das showed he continue from hitting his he implemented as w. During an observation individual #1's one Individual #1's hel usually kept in Ind. of the entertainment they were told by the thind they were told by the thind they were to be they was her first time. When asked about not know the plan and cried. She rethey were to put they was not Manda Individual #1's The Administrator assignments on 9 the RSC made they was present, was making staffing as not use any criteris she "just rotate state" On 9/15/10 at 11:4 assigned staff per	PROVIDER OR SUPPLIER RRED COMMUNITY HOMES - COURTYARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his BIP was not implemented as written. During an observation on 9/14/10 at 7:26 a.m., Individual #1's one-to-one staff was asked about Individual #1's helmet. The staff stated it was usually kept in Individual #1's bedroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at all	PROVIDER OR SUPPLIER RRED COMMUNITY HOMES - COURTYARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his BIP was not implemented as written. During an observation on 9/14/10 at 7:26 a.m., Individual #1's one-to-one staff was asked about Individual #1's helmet. The staff stated it was usually kept in Individual #1's bedroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at all times. During an observation at the facility on 9/14/10 at 2:55 p.m., the staff person assigned to Individual #1 was asked about her training. She reported it was her first time working with Individual #1. When asked about her training. She reported it was her first time working with Individual #1. When asked about her training that staff behad, they were to put the helmet on Individual #1 for 2 minutes. When asked, the staff person reported she was not Mandt certified. It was noted she had Individual #1's backpack on her person. The Administrator was interviewed about staffing assignments on 9/14/10 at 3:40 p.m. He reported the RSC made the assignments. The RSC, who was present, was asked about criteria used when making staffing assignments. She stated she did not use any criteria to make decisions; she stated she "just rotate staff." On 9/15/10 at 11:45 a.m., Individual #1 and his assigned staff person were noted to be walking	PROVIDER OR SUPPLIER RRED COMMUNITY HOMES - COURTYARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his BIP was not implemented as written. During an observation on 9/14/10 at 7:26 a.m., Individual #1's ne-to-one staff was asked about Individual #1's helmet. The staff stated it was usually kept in Individual #1's bedroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at al! times. During an observation at the facility on 9/14/10 at 2:55 p.m., the staff person assigned to Individual #1 was asked about her training. She reported it was her first time working with Individual #1. When asked about his BIP, she stated she did not know the plan but believed he head banged and cried. She reported if he banged his head, they were to put the helmet on Individual #1 for 2 minutes. When asked, the staff person reported she was not Mandt certified. It was noted she had Individual #1's backpack on her person. The Administrator was interviewed about staffing assignments on 9/14/10 at 3:40 p.m. He reported the RSC made the assignments. The RSC, who was present, was asked about criteria used when making staffing assignments. She stated she did not use any criteria to make decisions; she stated she "just rotate staff." On 9/15/10 at 11:45 a.m., Individual #1 and his assigned staff person were noted to be walking	A BUILDING B. WINNG RRED COMMUNITY HOMES - COURTYARD SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WINDS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his BIP was not implemented as written. During an observation on 9/14/10 at 7:26 a.m., individual #1's helmet. The staff stated it was usually kept in Individual #1's bacroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at all times. During an observation at the facility on 9/14/10 at 2:55 p.m., the staff person assigned to Individual #1. When asked about his BIP, she stated she did not know the plan but believed he head banged and cried. She reported if he banged his head, they were to put the helmet on Individual #1 for 2 minutes. When asked, the staff person reported she was not Mandt certified. It was noted she had Individual #1's backpack on her person. The Administrator has displayed a understanding of the Quality Assurance measures. Person Responsible: Tom M Assistant to the Regional Add Completion Date: 10/20/10 PREPERY TAGE STATE, ZIP CODIG 15 T	The Abullunos A BULLINOS

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	IOMES - COURTYARD	615	ET ADDRESS, CITY, STATE, ZIP C SECOND AVENUE WEST ENDELL, ID 83355		
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W 193	or backpack. The about her training with Individual #1 Individual #1 Individual #1 Individual #1 Individual #1's BIF and tried to keep behaviors consisted banging, and bittin his head, she blood she thought he had be bedroom and staff stated that if they were to tell hon the helmet. The not Mandt certified direct care staff with they were to tell hon the helmet. The facility failed Individual #1 were such that they comproted him from \$1.00 Appropriate facility interdisciplinary to the standard was determined to the proper such that they comprometed the proper such that they comproted the following interdisciplinary to the standard to the potential for a information being IPPs and a lack of members to consider the standard propersists to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of members to consider the potential for a information being IPPs and a lack of the potential for a information being IPPs and a lack of the potential for a lack of the pot	staff was carrying the helmet staff was asked, at that time, She reported she did not work very often. When asked about she stated she talked to him happy. She stated his ed of running out the door, head g himself. She reported if he hit sked with her hand. She stated id a helmet and stated it was in 'it's always kept there." The he continued head banging, im that they were going to put he staff person reported she was id. It was noted that no other ere present in the facility. It oensure staff assigned to be sufficiently trained on his BIP all appropriately intervene and self abuse. DIVIDUAL PROGRAM PLAN by staff must participate in	W 193	W 207 483.440(c)(2) IN PROGRAM PLAN Preferred Community Homeetings for all individual An experienced QMRP whome to coordinate the II The Administrator verificand a direct care staff partippe meetings. At the time meetings the AQMRP rein regards to the importation appropriate staff attend to A new Administrator/QN hired and assigned to wo Courtvard Facility. Her	omes held IPP als on 9/28/10. was sent to the PP meetings. ed that the LPN recipated in the ne of the ceived training nee of having the meetings.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	DMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREF TAC	i	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 207	1. Individual #3's 2/year old male whos profound mental re He was a ward of tappointed Case Male Individual #3's IPP Manager (via phonous QMRP, the AQMR IPP. There was no evident nursing personnel in the meeting. When asked about staff, the Administron 9/16/10 from 1:1 was identified about parent company consurvey. 2. Individual #1's IPhimself, his parent QMRP, the AQMR (via phone) attended There was no evident nursing personnel in the meeting. When asked about staff, the Administron 9/16/10 from 1:1 was identified about staff, the Administron 9/16/10 from 1:1 was identified about parent company consurvey.	se diagnoses included tardation, ADHD, and autism. he state and had a state anager. showed himself, his Case e), the Administrator, the P, and the RSC attended his ence direct care staff or were encouraged to participate at the attendance of direct care stator stated during an interview of 5 - 1:50 p.m., that the problem at six months ago when the enducted a quality assurance of the Administrator, the P, and the Behavior Specialist	W	207	10/13/10. The new Administrative staff including importance of assuring that adstaff participates in the IPP me The Assistant to the Regional Administrator has been assigned provide supervision to the CoulCF/MR. He will spend a minifour days per month in the We completing Quality Assurance to assure that compliance with regulations is maintained. One the Quality Assurance measure includes reviewing the IPP's to that adequate staff participates meetings. After the program Administrator has displayed a understanding of the Quality Aprocess, she will be assisting a Quality Assurance measures. Person Responsible: Tom Mc Assistant to the Regional Administrator Date: 10/20/10	the equate equate etings. ed to ortyard imum of ondell area measures e part of es o assure in the clear assurance vith	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
	13G057	B. WING			09/16/2010		
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HO	MES - COURTYARD		615	SECOND AVENUE WEST NDELL, ID 83355	, ZIP CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
the QMRP, the AQM his IPP. There was no evide nursing personnel win the meeting. When asked about staff, the Administration 9/16/10 from 1:0 was identified about parent company consurvey. The facility failed to encouraged attend to Individuals #1 - #3. W 214 W 214 The comprehensive identify the client's subhavioral manager. This STANDARD is Based on observation interview it was determined behavioral acomprehensive information of intervention decision. Individual #3's 2/1 year old male whose.	(via phone), the Administrator, MRP, and the RSC attended note that direct care staff or vere encouraged to participate the attendance of direct care stor stated during an interview 5 - 1:50 p.m., that problem is six months ago when the inducted a quality assurance ensure facility staff were the IPP meetings for DIVIDUAL PROGRAM PLAN is functional assessment must specific developmental and	W	214	W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM P Preferred Community Homes h meetings for all individuals on An experienced QMRP was ser home to coordinate the IPP med During the meetings the behavit assessments were discussed and being revised based on the curr needs of the consumers. A new Administrator/QMRP h hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrat receive training from current Administrative staff including to importance of assuring that all	peld IPP 9/28/10. Int to the etings. It is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI ILDING	LE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
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W 214	mg each evening a drug) 80 mg each of drug, the provide and documented the sold of drug each	idone (an antipsychotic drug) 3 and Geodon (an antipsychotic devening. e conference on 9/13/10 at ious QMRP stated Individual behavior management program it maladaptive behaviors. al #3's Incident/Accident (10 to 9/13/10, were reviewed the following: m.: Individual #3 slapped s the face. m.: Individual #3 hit Individual m.: Individua	W	214	assessments are kept current to the needs of the consumers. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a mining four days per month in the Wend completing Quality Assurance in to assure that compliance with regulations is maintained. One puthe Quality Assurance measures includes reviewing the current assessments to assure that the assessments are up to date and a based on the needs of the consumant After the program Administrator displayed a clear understanding Quality Assurance Process, she assisting with Quality Assurance measures. Person Responsible: Tom Most Assistant to the Regional Adminic Completion Date: 10/20/10	d to tyard num of dell area neasures part of cccurate mers. r has of the will be e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		13G057	B. WING			I	C 09/16/2010	
NAME OF PROVIOER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD				618	ET ADDRESS, CITY, STATE, ZIP COD 5 SECOND AVENUE WEST ENDELL, ID 83355	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 214	down to the floor to spinning, running to down when excited and cold. [Individuate to his interests - widemands people's Individual #3's Behidentified maladap monitored informal "Inattentive-hypera which stated "Forn program for following Further, Individual stated he had a his pinches, pulls hair) bites self) and Unu The Behavioral As maladaptive behav formal behavioral stracking sheet, dat	chavior, defined as "crouching avoid tasks or requests." behavior, defined as "flapping, back and forth, jumps up and d, and is tactile sensitive to hot hal #3] wants people to attend hich change rapidly. He attention." avioral Assessment stated all tive behaviors were to be ally with the exception of a support provided ADL and one-step directions." #3's Behavioral Assessment story of "Aggression (hits, bites, by Self abuse (pulls own hair, asual behavior (bites objects)." sessment stated historical viors were "Monitored - no support needed at this time." al #3's record included a data and 2/10, which documented vior totals from 2/1/10 - 2/9/10, 6	W	214				

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 09/29/2010 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	13G057		B. WING			C 09/16/2010		
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
W 214	- Running from staf - Putting objects in - Throwing objects - Attempts to throw Additionally, Individ 7/1/10 - 9/15/10, do maladaptive behav 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 2 - Dropping to groun 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 2 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 3 - Non-compliant = 3 - Dropping to groun No Behavior Slips of Individual #3's Beh adequately address behaviors. During an interview p.m., the Administr maladaptive behav assessment neede	f = 79 mouth = 17 = 117 objects = 2 ual #3's Behavior Slips dated ocumented the following fors: 23 ad = 37 24 342 ad = 169 could be located for 9/10. avioral Assessment did not songoing maladaptive y on 9/16/10 from 1:05 - 1:50 ator stated Individual #3's fors were not new, and the	W	214				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		13G057	B. WIN	1G			C 6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 15 SECOND AVENUE WEST /ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 214	developed to capture maladaptive behave 2. Individual #2's IF a 19 year old male mental retardation During the entrance 3:00 p.m., the Admit team that Individual supervision due to Observations were 9/14/10 for a cumur During that time, In a one-to-one staff However, Individual dated 4/1/10 and refor assess his need When asked, the A interview on 9/16/1 Individual #2's Beh be revised. The facility failed to behavioral assess comprehensive information objectives necessal as identified by the	nent was adequately re and assess his ongoing iors. PP, dated 4/29/10, documented diagnosed with profound and autism. e conference on 9/13/10 at inistrator informed the survey I #2 required one-to-one maladaptive behavior. conducted at the facility on lative 4 hours 6 minutes. dividual # 2 was noted to have berson assigned to him. II #2's Behavior Assessment, evised 8/8/10, did not identify for one-to-one staff. administrator stated during an 0 from 1:05 - 1:50 p.m., avior Assessment needed to be ensure Individual #2's ment contained clear and	w:		W 227 483.440(c)(4) INDIVII PROGRAM PLAN Preferred Community Homes has IPP meeting for individual #3. experienced QMRP was sent to home to coordinate the IPP meeting the meeting individual #	eld an An the eting.	

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			URVEY ETED
		13G057	B. WIN	G			C 6/2010
	ROVIDER OR SUPPLIER	HOMES - COURTYARD		615	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF C		ULD BE	(X5) COMPLETION DATE
W 227	This STANDARD Based on observa interviews it was of ensure individuals meet their needs #3) whose IPPs a This resulted in a to address the ne most likely to implinctude: 1. Individual #3's year old male who profound mental of During the entrant 3:00 p.m., the for did not have a be he did not exhibit However, Individual Reports, dated 7/ and documented - 8/16/10 at 5:30 Individual #2 acro - 8/17/10 at 2:40 #4 on the hand. - 8/17/10 at 3:00 #4 on the arm. - 8/21/10 at 3:00 #4 on the arm. Additionally, Individually, Individual	is not met as evidenced by: ation, record review, and staff determined the facility failed to by IPPs included objectives to for 1 of 3 individuals (Individual and objectives were reviewed, lack of program plans designed eds of an individual in areas act his life. The findings 2/16/10 IPP stated he was a 12 bee diagnoses included retardation, ADHD, and autism. ce conference on 9/13/10 at mer QMRP stated Individual #3 havior management program as maladaptive behaviors. all #3's Incident/Accident 1/10 to 9/13/10, were reviewed the following: b.m.: Individual #3 slapped	W 2	227	behavior needs were discussed a plan is being revised to include objective for his identified needs. A new Administrator/QMRP ha hired and assigned to work at the Courtyard Facility. Her first day 10/13/10. The new Administrative staff including the importance of assuring that all be assessments are kept current to the needs of the consumers and goal identified and objectives are writed indisplayed maladaptive behaviors. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minimal four days per month in the Wend completing Quality Assurance in to assure that compliance with regulations is maintained. One the Quality Assurance measures includes reviewing the current assessments to assure that the assessments are up to date and a based on the needs of the consumand that objectives are written for displayed maladaptive behavior the program Administrator has displayed a clear understanding Quality Assurance Process, she assisting with Quality Assurance measures. Person Responsible: Tom Mos Assistant to the Regional Administrator to the R	s been e y will be or will ne ehavior the ls are tten for dell area neasures part of cccurate mers or After of the will be e	
		ated 2/10, which documented avior totals from 2/1/10 - 2/9/10,			Completion Date: 10/20/10		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET AODRESS, CITY, STATE, ZIP COC 5 SECOND AVENUE WEST ENDELL, ID 83355		16/2010	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 227	7/1/10 - 9/15/10, do maladaptive behave 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 1 - Dropping to ground 10: - Slaps = 3 - Attempts to hit = 1 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 1 - Dropping to ground 10: - Streaming = 175 - Non-compliant = 10 - Dropping to ground 10: - Dropping to ground 10: - Dropping to ground 10: - Streaming = 175 - Non-compliant = 10: - Dropping to ground 10: - Streaming = 175	280 s = 28 nd = 303 ff = 79 mouth = 17 = 117 objects = 2 dual #3's Behavior Slips dated ocumented the following riors: 0 23 nd = 37		227				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL!	E CONSTRUCTION	(X3) DATE SU COMPLE	
		13G057	B. WING		1	C 6/2010
	ROVIDER OR SUPPLIER	HOMES - COURTYARD	615	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE WEST NDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID : PREFIX TAG :	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		cord did not contain plans to mented ongoing maladaptive	W 227			:
	p.m., the Administinterventions for developed. The facility failed Individual #3's or	ew on 9/16/10 from 1:05 - 1:50 strator stated behavioral ndividual #3 had not been to ensure objectives for agoing maladaptive behaviors				: : : :
W 237	Each written train implement the objection program plan mufrequency of data	INDIVIDUAL PROGRAM PLAN along program designed to bjectives in the individual est specify the type of data and a collection necessary to be able as toward the desired objectives.	W 237	W 237 483.440(c)(5)(iv) INDIVIDUAL PROGRAM P Preferred Community Homes I IPP meeting for individual #1 a individual #2. An experienced was sent to the home to coordin IPP meeting. During the mee	neld an and I QMRP nate the eting their	
	Based on record determined the fall data collected was efficacy of the infinitividuals (Individuals (Individuals en	is not met as evidenced by: review and staff interview, it was acility failed to ensure the type of as sufficient to determine the ervention strategies for 2 of 2 iduals #1 and #2) whose ation programs and behavior slips By not ensuring appropriate data cility could not make objective ing the individuals' success or		behavior needs were discussed was determined that a revised of would better document their discussed in maladaptive behavior. The cursheet comprehensively document maladaptive behavior. A new Administrator/QMRP hired and assigned to work at the Courtyard Facility. Her first discussed to the courtyard facility.	data sheet isplayed rrent data ents each has been the ay will be	
	1. Individual #1's a 21 year old ma mental retardation	The findings include: IPP, dated 3/12/10, documented le diagnosed with moderate in, pervasive developmental distinction and OCD traits.		receive training from current Administrative staff including importance of assuring that all maladaptive behavior displaye resident is documented on a comprehensive data sheet.	the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI ILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII	NG			C 6/2010
	PROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 237	Individual #1's BIP engaged in the followed listen and followed floor). - Physical aggress pinching, scratching butting). - Self abuse (definand head banging). - Elopement (definwithout staff). Individual #1's Belgottons titled Antoconsequence. State Antecedent an narrative format. However, under the was a list of intervent the BIP wounder the BIP wounder the intervent the exhibited malawas no information response to the intervent the exhibited malawas no inform	dated 3/12/10, stated he owing maladaptive behavior: chavior (defined as refusing to rections and dropping to the dion (defined as hitting, biting, ag, kicking, shoving, and head ed as biting self, hitting self, bed as leaving the facility defined. The Slips contained three decedent, Behavior, and aff were required to complete defined Behavior section in a defined and document the ach intervention was used. The data did not clearly specify thous were used in relation to idaptive behaviors and there are related to Individual #1's	W	237	The Assistant to the Regional Administrator has been assigned provide supervision to the Coul ICF/MR. He will spend a minimal four days per month in the We completing Quality Assurance to assure that compliance with regulations is maintained. One the Quality Assurance measure includes reviewing the current collection systems to assure the comprehensive data is collected the program Administrator has displayed a clear understanding Quality Assurance Process, she assisting with Quality Assurance measures. Person Responsible: Tom Mc Assistant to the Regional Adm Completion Date: 10/20/10	artyard imum of indell area measures e part of es data at ed. After is g of the e will be ace	

PRINTED: 09/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IULTIP ILDI N G	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII	NG		C 09/16/2010	
	ROVIDER OR SUPPLIER	DMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 237	room door." - Behavior: "[Individual #2's IFa 19 year old male maladaptive behaviors." - Behavior: "[Individual #2's BIP 8/10/10, stated he maladaptive behavior on the consequence of	dual #1] tried to go out the dining dual #1] attempted elopement in from leaving the house. He inself fall backwards) to the nead on edge of chair [sic]. Hit cked staff 5 times. Banged it times and attempted to head Behavior lasted 5 minutes. It gand screaming for another 5 minutes.		237			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	COMPLE	TED
		13G057	B. WIN	IG			C 6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		619	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		3,20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 237	- Uncooperative be attempts to elope unaccompanied be a Aggression (defined a Aggression	ehavior (defined as refusals and [leaving facility property y staff]). ned as hitting, slapping, and throwing objects). ned as biting self causing skin self causing skin damage and havior Slips, dated 7/1/10 - wed. The Slips contained three eccedent, Behavior, and aff were required to complete and Behavior section in a he section titled Consequence entions. Staff were to circle was followed and document the each intervention was used. The data did not clearly specify tions were used in relation to adaptive behaviors and there in related to Individual #2's	W:	237			
	8/23/10 from 2:00 following:	vidual #2's Behavior Slip, dated - 2:30 p.m., showed the empting to do fine motor ring beads [sic]."					
		mes, spit 3 times, burped 2 follow directions 15 times, and					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	TED
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	ROVIDER OR SUPPLIER	OMES - COURTYARD		6	REET ADDRESS, CITY, STATE, ZIP CODE 115 SECOND AVENUE WEST WENDELL, ID 83355	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 237	hand blocks: 15 tin Burping audibly/Sa It was not clear at and open hand blo Individual #2's mal Individual #2's respond documented. When asked, the A interview on 9/16/1 type of data collect. Without comprehe consequence of the possible for the facility would not the staff impler intervention, and was effective.	erbal cues: 31 times. Open nes. Spitting mask: 3 times. by "sorry:" 1 time. what point in time verbal cues oking occurred in relation to adaptive behavior. Further, bonse to the interventions was administrator stated during an 0 from 1:05 - 1:50 p.m., the ion was not adequate. Insive data regarding the elebehavior, it would not be ablity to adequately assess individuals' behavior pies were adequate. Further, but be able to identify whether or mented the appropriate the ther or not the intervention of ensure the type of data	W	237			
W 239	provided sufficient assess the efficacy 483.440(c)(5)(vi) If Each written training implement the object program plan must appropriate express replacement of ina	duals' maladaptive behaviors information to adequately of the intervention strategies. NDIVIDUAL PROGRAM PLAN ag program designed to ectives in the individual especify provision for the sion of behavior and the ppropriate behavior, if havior that is adaptive or	W	239	W 239 483.440(c)(5)(vi) INDIVIDUAL PROGRAM I Preferred Community Homes I IPP meeting for individual #1 individual #2. An experienced was sent to the home to coordi IPP meeting. During the mee behavior needs were discussed	held an and I QMRP nate the eting their	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL ILDING	LE CONSTRUCTION	(X3) DATE S COMPLE	TED
		13G057	B. WII	NG			C 6/2010
	PROVIDER OR SUPPLIER	OMES - COURTYARD	1	615	ET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 239	Based on record r determined the fact appropriate replact identified and incontrol intervention progra (Individuals #1 and intervention plans individuals not recomaladaptive behavior of the second managemental retardation disorder, and autistic lindividual #1's Bel 3/5/10, stated two and sustained his "Emotional nechis "continued difficultividual #1's BIF engaged in the followidual #1's BIF engaged in #1's	is not met as evidenced by: eview and staff interview, it was cility failed to ensure ement behaviors were reporated into the behavior ams for 2 of 2 individuals d #2) whose behavior were reviewed. This resulted in eiving training to replace viors. The findings include: PP, dated 3/12/10, documented d diagnosed with moderate d, pervasive developmental estic and OCD traits. Inavior Assessment, dated potential causes that elicited maladaptive behavior were that eds are still not being met" and iculty in expressing P, dated 3/12/10, stated he lowing maladaptive behavior: ehavior (defined as refusing to irections and dropping to the sion (defined as hitting, biting, ng, kicking, shoving, and head ned as biting self, hitting self,	W	239	replacement behavior objectives identified. The new IPP's are be implemented on 10/20/10 with a replacement behavior written objectives. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrative receive training from current Administrative staff including the importance of assuring that objector replacement behaviors are ideand implemented when needed. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minificulty four days per month in the Wend completing Quality Assurance at the total assure that compliance with regulations is maintained. One the Quality Assurance measure includes assuring that replacem behavior objectives are included IPP for any resident with a form behavior management plan. At program Administrator has dispersional administrator to the Regional Administrator to the Regional Administrator to the Regional Administrator Date: 10/20/10	seing the as been as been as will be tor will he ectives dentified d to rtyard mum of adell area measures part of s ent d on the nal fter the blayed a lity assisting res. ss,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER RED COMMUNITY HO	OMES - COURTYARD	\$	STREET ADDRESS, CITY, STATE, ZIP COD 615 SECOND AVENUE WEST WENDELL, ID 83355	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 239	- Elopement (define without staff). However, Individua any training plans rebehaviors as specific Assessment. When asked, the A 12:45 p.m., replaced developed for Individual #2's IP a 19 year old male mental retardation and Individual #2's Behavioral and potential causes the maladaptive behavioral to appropriately conneeds." Individual #2's BIP, 8/10/10, stated he emaladaptive behavioral and burping and burping - Property destructions and burping - Property destructions and burping - Uncooperative beattempts to elope [I unaccompanied by Individual by Individual by Individual by Individual beattempts to elope [I unaccompanied by Individual by Individ	ed as leaving the facility Il #1's record did not contain related to replacement fied in his Behavior AQMRP stated on 9/15/10 at rement behaviors were not ridual #1. PP, dated 4/29/10, documented diagnosed with profound and autism. avior Assessment, dated 8/8/10, stated that one of the replaced and sustained his recontinued inability mmunicate his wants and dated 5/20/10 and revised rengaged in the following rior: ial behaviors (defined as gloudly). Ion (defined as throwing and revised response of the reconstruction	W 23	39			
		ed as hitting, slapping, and throwing objects).				**************************************	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		13G057	B. WIN	IG			5 6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 239	- Self abuse (defined damage, pinching shitting self). According to Individual behavior for inapproverbalize the word replacement behavior to communicate his language. However, Individual any training plans rebehaviors as specially when asked, the Communicate self and the needs of Individual any training replacement behaviors as specially the facility failed to replacement behaviors as specially failed to replacement behaviors as specially failed to replacement behaviors as soon as the interplacement deformulated a client formulated a client reach client must restreatment program	ed as biting self causing skin self causing skin damage and dual #2's BIP, his replacement opriate social behavior was to "Hi." His BIP showed the vior for the remaining iors listed above, was for him is wants and needs using sign at #2's record did not contain related to the replacement fied in his BIP. 2MRP stated on 9/16/10 at plans related to Individual #2's viors were not developed. 2 ensure appropriate viors were developed to meet duals #1 and #2. 2 GRAM IMPLEMENTATION erdisciplinary team has is individual program plan, aceive a continuous active consisting of needed	w:		W 249 483.440(d)(1) PROGR IMPLEMENTATION As stated in the report the followactions were taken on 9/15/10 to the immediate jeopardy:	wing	
	and frequency to s objectives identified plan. This STANDARD	ervices in sufficient number upport the achievement of the d in the individual program is not met as evidenced by; eview and staff interviews, it			Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's house, use of a pillow and clear in related to individual #1's escala Since 9/15/10 Preferred Community Homes has assured that only Micertified and staff trained in his	dicators ation. anity ANDT	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NULTIPL ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII	NG			C 6/2010
	ROVIDER OR SUPPLIER	DMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 249	individual received consistent with his for 1 of 2 individual behavior intervention were reviewed. The experiencing ongoing abuse. The finding abuse. The finding 1. Individual #1's IF a 21 year old male mental retardation, disorder, and autis Individual #1's BIP "[Individual #1] will with one to one stawaking hours" Head behaviors included as biting self, hittin His BIP stated if he agitated (defined a face), staff were to (Happy, Sad, and reeling card that be feeling. If he attem helmet was to be untime to help keep hel	e facility failed to ensure an training and services behavior intervention program (Individual #1) whose on plan and behavior slips is resulted in an individual ing head injures from self is include: PP, dated 3/12/10, documented diagnosed with moderate pervasive developmental tic and OCD traits. I dated 3/12/10, stated remain safe by being provided iffing within arm's length, during is BIP stated his maladaptive self abuse which was defined g self, and head banging. I showed signs of becoming getting an angry look on his show him the feeling cards Angry) and have him pick a lest described how he was noted to bang his head, his issed for up to two minutes at a nim safe from injury. I dent/Accident Reports and led 1/5/10 and 7/10 - 9/7/10, led to sustain head injuries ad, and his BIP was not	W	249	Addendum has worked with hir 9/26/10 all the staffs allowed to with individual #1 were trained BIP. There were some staff that not MANDT certified and other were hired after this that were in allowed to work with him. Pred Community Homes has conduct observations on the AM and PM since 9/15/10 to assure that the been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred discuss individual #1's needs. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrate receive training from current Administrative staff including the importance of assuring that all the Plans are implemented so that consumers are to be assisted to safe at all times. The Assistant to the Regional Administrator has been assigned provide supervision to the Courty-MR. He will spend a minifour days per month in the Wert completing Quality Assurance to assure that compliance with regulations in maintained. One the Quality Assurance measure includes reviewing Incident and Accident reports and doing obstot assure that each consumer we facility is safe and that their progression implemented as written as written as written as we with the progression in the prog	work on his at were rs that tot ferred ted A shifts BIP has munity ed to as been ne by will be tor will the Behavior remain d to rtyard mum of adell area measures e part of servations eithin the tograms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		13G057	D. WING	<u> </u>	09/16/2010	
	PROVIDER OR SUPPLIER	DMES - COURTYARD	61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLÉTION	
W 249	behavior" and "mac corresponding Nursthe back of his head corner of a wall result where 8 staples we wound. His Behavior Slip, overbal cues and op was documented the helmet were not us -7/7/10 at 3:50 p.m hit his head on the injury" resulting in a Behavior Slip documented the helmet were not us -7/12/10 at 9:30 a. the front door. Who down on the sidew cement. He "reope in a ½ inch abrasio forehead. His Behavior Slip show apparent injury was apparent injury was Behavior Slip show 2 times, and hit his Further, the Behavior the show a sh	n.: Individual #1 "went into a de himself fall backwards." A se's Note documented he hit d on a chair and then on the sulting in a laceration. Tansported to the local hospital ere inserted to close the dated 1/5/10, documented ten hand blocking were used; it hat his feeling cards and ted as per his BIP. n.: Individual #1 dropped and floor. He "reopened head a ½ inch abrasion. His mented verbal cues, open body positioning were used; it hat his feeling cards and ted as per his BIP. m.: Individual #1 "darted" out en staff blocked him, he sat alk and hit his head on the ened cut on forehead" resulting in to his upper middle avior Slip documented verbal itioning were used; it was is feeling cards and helmet	W 249	the event that a safety concern is identified, the Assistant to the R Administrator has been given the instruction to take immediate concern and remain in the facility each consumer is safe from harmonistrator has displayed a clear understanding Quality Assurance Process, she assisting with Quality Assurance measures. Person Responsible: Tom Mos Assistant to the Regional Admin Completion Date: 10/20/10	regional e orrective until n. After of the will be e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIP LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WI	NG		C 09/16/2010	
	ROVIDER OR SUPPLIER	OMES - COURTYARD	•	61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	≀D PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	followed as written - 8/22/10 at 1:50 p. on the living room injury. His Behavior the question as to as written. - 8/31/10 at 6:30 p. from going outside room door resulting 1/2 inch diameter luverbal cues, open positioning were us feeling cards and hBIP. - 9/1/10 at 1:00 p.r gate" [sic] and hit had riveway. He "operesulting in "1/2 inch 8/31/10." There w Slip. - 9/1/10 at 4:00 p.r gate" [sic] and hit had riveway. He "operesulting in an "abradiameter." There is Slip. - 9/2/10 from 2:00 "banged his head resulting in "another lump 2 [inches] diafluid filled." Individ hospital for evalual	m.: Individual #1 hit his head wall. There was no apparent or Slip documented "no" next to whether his BIP was followed m.: Individual #1 was blocked. He hit his head on the dining g in a ½ inch abrasion with a 1 mp. His Behavior Slip showed hand blocking, and body sed; it was documented that his helmet were not used as per his in: Individual #1 "got out the his head on the concrete and scabbed forehead" along [sic] reopened from as no corresponding Behavior n.: Individual #1 "got out the his head on the concrete and scabbed forehead" ased [sic] area now 1 inch in was no corresponding Behavior - 3:00 p.m.: Individual #1 on the sidewalk and on the dirt" ar ½ cm abrasion to forehead, ameter mushy poss (possibly) ual #1 was taken to the	W	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII			C 09/16/2010	
	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
W 249	Behavior Slips, dar following: - At 2:00 p.m.: He times; it was docur question as to whe written. - At 2:30 p.m.: He times; it was docur question as to whe written. - At 3:30 p.m.: He it was documented whether his BIP w. - 9/4/10 at 5:30 p.m. and "banged his h. There were no app. Slip documented whether his BIP w. - 9/4/10 at 2:45 p.m. behavior" and staff outside. "He went on the dining room on his forehead." Follow-Up section inch reopen old we corresponding Bel. After reviewing Increports the evenin AQMRP, and RSC facility's office, we protecting Individual injuries. They were	hit his head on the ground 2 mented "no" next to the ether his BIP was followed as hit his head on the ground 2 mented "no" next to the ether his BIP was followed as hit his head on the ground 2 mented "no" next to the ether his BIP was followed as hit his head on the table 1 time; d "no" next to the question as to as followed as written. m.: Individual #1 ran outside ead on the grass 5 times." carent injuries. His Behavior "no" next to the question as to as followed as written. m.: Individual #1 "went in to a f stopped him from going to the ground" and hit his head in floor. He "reopened the cut According to the Nursing of the report, he sustained a "1/4 bound [sic]." There was no		249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G057	B. WII			C 09/16/2010	
	PROVIDER OR SUPPLIER	OMES - COURTYARD		61	EET ADDRESS, CITY. STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)			ULD BE	(X5) COMPLETION DATE
W 249	12:45 p.m., she was showed Individual implemented or fol helmet was not beiled. When asked, the Continued in the QMRP reported did not document to the Individual #1 requires when he his continued to sustait documentation shows consistently in that he was protect 483.440(f)(2) PROCHANGE At least annually, the must be revised, a process set forth in This STANDARD Based on observation individuals (Individuals responded to the inindividuals (Individuals Individuals (Individuals Treviewed. The Individuals Individuals (Individuals Individuals (Individuals Individuals I	is aware the documentation #1's BIP was not being lowed as written, and his ng used. QMRP stated on 9/15/10 at noted in the documentation BIP was not implemented or have called a team meeting. It do they had team meetings but hem. Ted one-to-one arm's length helmet to protect him from this head. However, he nongoing head injuries and owed his BIP was not lowed as written. The ensure Individual #1's BIP inplemented and followed such ted from ongoing head injuries. GRAM MONITORING & The individual program plan is appropriate, repeating the in paragraph (c) of this section. The individual program plan is appropriate, repeating the inparagraph (c) of this section. The individual program plan is appropriate, repeating the inparagraph (c) of this section. The individual program plan is appropriate, repeating the inparagraph (c) of this section. The individual program plan is not met as evidenced by: The individual program plan is not met as evide		249	W 260 483,440(f)(2) PROGR. MONITORING & CHANGE Preferred Community Homes h IPP meeting for individual #1 a individual #2. An experienced was sent to the home to coordin IPP meeting. During the meet behavior needs were discussed a plans were revised to include th current needs. A new Administrator/QMRP ha hired and assigned to work at th Courtyard Facility. Her first da 10/13/10. The new Administra	eld an nd QMRP nate the ting their and their neir as been ne	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		13G057	B. WING			1	C 6/2010	
	PROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 260	a 19 year old male mental retardation Individual #2's BIP elopement behavior property unaccomputers were no instrintervene if the belief When asked, the Arinterview on 9/16/1 Individual #2 did not simply went outsid. The Administrator and Individual #1's IF a 21 year old male mental retardation disorder, and autist Individual #1's IPP currently attended difficulty transitioni. However, during of 9/14/10 for a cumulatividual #1 was a day treatment progracility. When asked, the Arinterview on 9/16/1 Individual #1 gradus spring and his IPP	PP, dated 4/29/10, documented diagnosed with profound and autism. stated he engaged in or (defined as leaving facility banied by staff). However, uctions to staff on how to havior occurred. Administrator stated during an 0 from 1:05 - 1:50 p.m., ot elope from the facility; he se to swing in the backyard. Stated it was a definition issue BIP needed to be revised. PP, dated 3/12/10, documented diagnosed with moderate pervasive developmental	W:	260	receive training from current Administrative staff including to importance of assuring that all I revised annually or as needed. The Assistant to the Regional Administrator has been assigned provide supervision to the Cour ICF/MR. He will spend a minificour days per month in the Wencompleting Quality Assurance into assure that compliance with regulations is maintained. One the Quality Assurance measures includes assuring that all IPP's revised annually or as needed. A program Administrator has dispolar understanding of the Qual Assurance Process, she will be with Quality Assurance measuremeasure. Person Responsible: Tom Mos Assistant to the Regional Admin Completion Date: 10/20/10	d to tyard num of dell area neasures part of are After the alayed a ity assisting es.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	IOMES - COURTYARD	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355				
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W 260	Continued From p	age 44	W 260			1000	
W 266	Individual #2s' IPF 483.450 CLIENT I PRACTICES	•	W 266	W 266 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES	7		
	behavior and facili met.	ity practices requirements are		Please refer the plans of corn given for W214, W227, W2: W278, W285, W289, W312	37, W239,		
	Based on observal record review, and determined the facused to manage ir sufficiently develo and closely monitorindividuals not record.	is not met as evidenced by: ation, incident/accident reports, d staff interviews it was cility failed to ensure techniques happropriate behavior were ped, consistently implemented, bred. This failure resulted in heiving appropriate behavioral wentions. The findings include:					
	failure to ensure b	as it relates to the facility's behavioral assessments were ensive, and accurately identified ioral needs.					
	failure to ensure b	as it relates to the facility's ehavioral objectives were ess an individual's maladaptive					
	failure to ensure d	as it relates to the facility's ata collection was sufficient to cacy of individuals' behavior gies.					
	failure to ensure th	as it relates to the facility's ne replacement plans for aptive behavior were developed avioral needs.					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER RED COMMUNITY H	OMES - COURTYARD	5	STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PR E FIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	
W 266	Continued From pa	age 45	W 26	66		
	failure to ensure le were systematicall	as it relates to the facility's ss restrictive interventions y tried and proven to be implementing restrictive				
	failure to ensure the inappropriate beha sufficient safeguar	as it relates to the facility's at techniques to manage vior were employed with ds and supervision to ensure ety, welfare and civil and human ed.				
	failure to ensure th	7. Refer to W289 as it relates to the facility's failure to ensure that techniques used to manage inappropriate behavior were incorporated into the			This could be a second of the	
	failure to ensure be used only as a con individual's IPP tha towards the reduct	as it relates to the facility's ehavior modifying drugs were aprehensive part of an at was directed specifically ion of and eventual elimination r which the drugs were				
	failure to ensure be not used until the s	as it relates to the facility's ehavior modifying drugs were severity of the behavior was he associated risks of the				
W 278	CLIENT BÊHÂVÍO		W 27	W 278 483.450(b)(1)(iii) MO INAPPROPRIATE CLIENT BEHAVIOR		
	inappropriate clien the use of more re	t behavior must insure, prior to strictive techniques, that the suments that programs		Preferred Community Homes IPP meeting for individual #3 experienced QMRP was sent to	. An	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	DMES - COURTYARD	•	6	REET ADDRESS, CITY, STATE, ZIP CODE 15 SECOND AVENUE WEST VENDELL, ID 83355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 278	This STANDARD Based on record re was determined the individuals' records restrictive or more utilized prior to the techniques to mana individuals (Individual interventions were potential for an indi restrictive intervent findings include: 1. Individual #3's 2/ year old male whos profound mental re During the entrance 3:00 p.m., the QMF have a behavior manot exhibit maladap However, Individual Reports and Behav 9/13/10, document behaviors that inclu hitting, slapping, ha elopement, non-co mouth, and throwin Individual #3's Physical documented he recantipsychotic drug)	se of less intrusive or more have been tried systematically to be ineffective. s not met as evidenced by: eview and staff interviews, it is facility failed to ensure included evidence of least positive techniques being use of more restrictive age behavior for 1 of 3 ual #3) whose restrictive reviewed. This resulted in the vidual to be subjected to ions unnecessarily. The 16/10 IPP stated he was a 12 se diagnoses included tardation, ADHD, and autism. If conference on 9/13/10 at RP stated Individual #3 did not anagement program as he did otive behaviors. I #3's Incident/Accident rior Slips, from 7/1/10 - ed he engaged in maladaptive ided, but were not limited to, air pulling, screaming, mpliance, putting objects in his	W	278	home to coordinate the IPP mee During the meeting individual # behavior needs were discussed a plans were revised to include the current needs. Currently Individe #3's psych medications are being reviewed at the PCH office as p the psych clinic instead of a prive physician. This way changes can monitored and input can be take all team members prior to a meeting implemented. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first day 10/13/10. The new Administrative receive training from current Administrative staff including the importance of assuring that less restrictive interventions are attemption to implementing restrictive components in an IPP. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minimate four days per month in the Wencompleting Quality Assurance in to assure that compliance with regulations is maintained. One the Quality Assurance measures includes assuring that lesser restinctive components in an IPI the program Administrator has displayed a clear understanding Quality Assurance Process, she	and their eir dual ag art of vate an be en from dication as been be en from the en fro		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 278	Continued From pa evening. The Phys the purpose of the	sician's Order did not document	W	278	assisting with Quality Assuran	ce	
	Individual #3's Writ Risperidone, dated "should further incr	ten Informed Consent for 8/24/10, stated the drug rease [Individual #3's] ability to and increase his time on task."			Person Responsible: Tom Mo Assistant to the Regional Adm Completion Date: 10/20/10		
	8/24/10, for Geodo	nformed Consent, dated n stated the drug was to [Individual #3] in controlling his iors."					
	Geodon were used but his record did r	ual #3's Risperidone and I for behavioral intervention, not clearly define which riors they were used for.					
	p.m., the Administres QMRP, stated the	v on 9/16/10 from 1:05 - 1:50 rator, who was also the acting drugs were for maladaptive did not know which specific					
	interventions being proven to be ineffe	nce of less restrictive g systematically tried and active prior to the use of g drugs to could not be found in active.					
	p.m., the Administration of any less restrict prior to the use of	v on 9/16/10 from 1:05 - 1:50 rator stated he was not aware ing interventions being used the behavior modifying drugs, tempted less restrictive ot exist.					
		o ensure less restrictive been systematically tried and		;	:		

PRINTED: 09/29/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A. BUILDING С B. WING 13G057 09/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST PREFERRED COMMUNITY HOMES - COURTYARD WENDELL, ID 83355 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 278 Continued From page 48 W 278 i proven to be ineffective prior to the use of restrictive behavior modifying drugs for Individual W 285 483.450(b)(2) MGMT OF INAPPROPRIATE W 285 W 285 483.450(b)(2) MGMT OF CLIENT BEHAVIOR INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient As stated in the report the following safeguards and supervision to ensure that the actions were taken on 9/15/10 to abate safety, welfare and civil and human rights of the immediate jeopardy: clients are adequately protected. Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet This STANDARD is not met as evidenced by: use, use of a pillow and clear indicators Based on observation, record review, and staff related to individual #1's escalation. interview it was determined the facility failed to Since 9/15/10 Preferred Community ensure techniques to manage inappropriate Homes has assured that only MANDT behavior were employed with sufficient certified and staff trained in his safeguards and supervision to ensure the safety, Addendum has worked with him. By welfare and civil and human rights for 1 of 2 9/26/10 all the staffs allowed to work individuals (Individual #1) whose behavior with individual #1 were trained on his intervention program was reviewed. This resulted BIP. There were some staff that were in a lack of adequate protections related to an

individual's physical safety. The findings include:

a 21 year old male diagnosed with moderate

mental retardation, pervasive developmental

Individual #1's BIP also showed he engaged in elopement which was defined as leaving the

facility without staff. The BIP stated if he left the

facility and sat somewhere that was unsafe (the

walking-moving restraint to immediately remove

him from the area to ensure his safety. His BIP did not include directions to staff as to where the

middle of the road or parking lot), staff were to

disorder, and autistic and OCD traits.

use his gait belt and/or a 2 person

1. Individual #1's IPP, dated 3/12/10, documented

not MANDT certified and others that

were hired after this that were not allowed to work with him. Preferred

Community Homes has conducted

observations on the AM and PM shifts

since 9/15/10 to assure that the BIP has

been followed. Preferred Community Homes has assured that weekly

behavior meetings have occurred to discuss individual #1's needs. During

the process the team made the decision

gait belt due to the fact that it is not an

effective tool to keep individual #1

from injuring himself.

to discontinue the use of individual #1's

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION IILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE WEST ENDELL, ID 83355			
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W 285	gait belt was to be Observations were 9/14/10 for a cumu During that time, In about Individual #1 was kept in his bedentertainment cent When asked, both on 9/15/10 at 12:45 been used since so Behavior Slips date documented the ga of those occasions was in the fenced than unsafe area. Individual #1 requir supervision and a gunsafe areas. How the belt was used, yard. Further, his geasy access of his sufficiently develop about the locality of the facility failed to was sufficiently develop about the BEHAVIO. The use of system inappropriate clientincorporated into the system incorporated into the system in system i	conducted at the facility on lative 4 hours 6 minutes. dividual #1's staff were asked 's gait belt. Staff reported it lroom or on top of the er in the living room. the AQMRP and RSC stated 5 p.m., the gait belt had not ometime in 2008. However, ed 7/20/10 and 9/4/10 ait belt was used, and on both it was documented that he back yard of the facility, not in led one-to-one arm's length gait belt to remove him from ever, on two occasions when he was in the fenced back gait belt was not kept within staff and his BIP was not led to include directions to staff of the belt. The ensure Individual #1's BIP reloped to protect him from aint with the gait belt. AT OF INAPPROPRIATE	W 2		A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrative staff including the importance of assuring that all its Plans are developed so that contained are to be assisted to remain safe times. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minificated away per month in the West completing Quality Assurance at the assure that compliance with regulations in maintained. One the Quality Assurance measure includes reviewing data, Incide Accident reports and doing obstoto assure that each consumer with facility is safe and that their plass of sufficiently developed to protect from harm. In the event that a concern is identified, the Assist the Regional Administrator has given the instruction to take im corrective action and remain in facility until each consumer is sharm. After the program Administrator has displayed a cunderstanding of the Quality A Process, she will be assisting would the Regional Administrator measures. Person Responsible: Tom Mon Assistant to the Regional Administrator Date: 10/20/10	the y will be tor will be to will be to will be to be		

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST			
				WE	ENDELL, ID 83355	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE-	(X5) COMPLETION DATE	
	Based on observation interviews it was defensure techniques behavior were suffincorporated into the individuals (Individuals (Individuals (Individuals' behavior findings include: 1. Individual #3's 2 year old male whose profound mental results of the did not exhibit results of	is not met as evidenced by: ion, record review, and staff etermined the facility failed to used to manage inappropriate iciently defined and ne program plans for 3 of 3 uals #1 - #3) whose program wed. This resulted in a lack of ntions being in place to ensure oral needs were met. The /16/10 IPP stated he was a 12 se diagnoses included etardation, ADHD, and autism. e conference on 9/13/10 at ner QMRP stated Individual #3 avior management program as naladaptive behaviors. al #3's Incident/Accident /10 to 9/13/10, were reviewed ne following: .m.: Individual #3 slapped	W	289	W 289 483.450(b)(4) MGMT INAPPROPRIATE CLIENT BEHAVIOR Preferred Community Homes he meetings for all individuals on an experienced QMRP was sen home to coordinate the IPP meetouring the meetings the behavior assessments were discussed and being revised based on the currenceds of the consumers as well behavior management plans. The information is being incorporate the BIP. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first date 10/13/10. The new Administrative receive training from current Administrative staff including the importance of assuring that all a documented in the behavior management plans. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minimal four days per month in the Wercompleting Quality Assurance in the completing Quality Assurance in the control of the	eld IPP D/28/10. It to the stings. For a recent as the he ed into as been as y will be tor will he needs are d to tyard mum of adell area		
	i #4 on the arm. - 8/21/10 at 3:00 p : #4 on the arm.	.m.: Individual #3 hit Individual		:	to assure that compliance with regulations is maintained. One the Quality Assurance measure includes reviewing the current and BIP's to verify that all need	part of s IPP's		
	tracking sheet, dat	dual #3's record included a data and a detail ed 2/10, which documented a vior totals from 2/1/10 - 2/9/10,			properly incorporated into each The Administrator will immedi	plan.		

PRINTED: 09/29/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 289	7/1/10 - 9/15/10, do maladaptive behave 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 10 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 10 - Dropping to ground 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 10 - Grabbing = 11 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 10 - Dropping to ground 10	280 = 28 nd = 303 ff = 79 mouth = 17 = 117 r objects = 2 dual #3's Behavior Slips dated ocumented the following riors: 0 23 nd = 37	**************************************	289	notified if discrepancies are fou corrective action can be taken. the program Administrator has displayed a clear understanding Quality Assurance Process, she assisting with Quality Assurance measures. Person Responsible: Tom Mos Assistant to the Regional Admit Completion Date: 10/20/10	After of the will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
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W 289	Continued From pa	nge 52	W	289			! ! !
:		ord did not contain plans to ented ongoing maladaptive					
	p.m., the Administra	on 9/16/10 from 1:05 - 1:50 ator stated behavioral dividual #3 had not been		:			
		ensure plans were developed al #3's ongoing maladaptive					
	interviews it was de ensure techniques behavior were suffi incorporated into the individuals (Individuals was a lack of appropriate	ne program plans for 2 of 3 uals #1 and #2) whose ere reviewed. This resulted in the interventions being in place list behavioral needs were met.					
	a 21 year old male	PP, dated 3/12/10, documented diagnosed with moderate pervasive developmental cic and OCD traits.					
	maladaptive behav	IP, dated 3/12/10, stated his iors included self abuse which ng self, hitting self, and head					1
	his helmet was to b	attempted to bang his head, be used for up to two minutes ep him safe from injury.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPL ILDING	LE CONSTRUCTION	(X3) DATE S COMPLI	ETED
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	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	ET ADDRESS, CITY, STATE, ZIP CODE S SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THI DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
W 289	Individual #1's Inci Behavior Slips, da showed he continu from hitting his he documented his he After reviewing Inc reports the evenin AQMRP, and RSC facility's office, we protecting Individu injuries. They wer asked where the h and RSC both star bedroom or on top the living room. W do if the head ban locations, they we Individual #1's BIP to include direction the helmet. b. Individual #1's I elopement which w facility without star His BIP stated if h somewhere that w road or parking lof and/or a 2 person immediately remo his safety. His BIP did not inc where the gait bel	dent/Accident Reports and ted 1/5/10 and 7/10 - 9/7/10, and to sustain head injuries ad and his Behavior Slips elmet was not used. dividual #1's Incident/Accident g of 9/13/10, the Administrator, who were present in the re asked how the facility was all #1 from ongoing head re unable to answer. When delmet was kept, the AQMRP ted it was kept either in his to of the entertainment center in when asked what staff were to ging occurred in other re unable to answer. If was not sufficiently developed has to staff about the locality of the staff were to use his gait belt was unsafe (the middle of the to), staff were to use his gait belt walking-moving restraint to the towe him from the area to ensure clude directions to staff as to the was to be kept.	W	289			
		e conducted at the facility on ulative 4 hours 6 minutes.			•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		13G057	B. WIN	IG		09/16	6/2010
	ROVIDER OR SUPPLIER RED COMMUNITY H	OMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 15 SECOND AVENUE WEST /ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 289	about Individual #1 was kept in his bed entertainment cent. When asked, both on 9/15/10 at 12:45 been used since so Behavior Slips date documented the gathose occasions, it in the fenced back unsafe area. Individual #1's BIP to include direction the belt. 3. Individual #2's IF a 19 year old male mental retardation During the entranc 3:00 p.m., the Adm team that Individual supervision due to Observations were 9/14/10 for a cumu During that time, In a one-to-one staff Individual #2's BIP 8/10/10, stated he maladaptive behave	adividual #1's staff were asked 's gait belt. Staff reported it droom or on top of the er in the living room. the AQMRP and RSC stated 5 p.m., the gait belt had not cometime in 2008. However, ed 7/20/10 and 9/4/10 ait belt was used and on both of was documented that he was yard of the facility, not in an was not sufficiently developed s to staff about the locality of PP, dated 4/29/10, documented diagnosed with profound and autism. e conference on 9/13/10 at ninistrator informed the survey of #2 required one-to-one maladaptive behavior. e conducted at the facility on lative 4 hours 6 minutes. Individual #2 was noted to have person assigned to him. dated 5/20/10 and revised engaged in the following rior:	W 2	289			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION ((X3) DATE SU COMPLE	
		13G057	B. WIN			09/16	6/2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		615	T ADDRESS, CITY, STATE, ZIP CODE SECOND AVENUE WEST NDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	- Uncooperative be attempts to elope [unaccompanied by - Aggression (defin scratching others, - Self abuse (defin damage, pinching hitting self). However, Individual information related needs. When asked, the A interview on 9/16/1 Individual #2's one requirement was not the facility failed to one-to-one staffing his BIP. 483.450(e)(2) DRU	ion (defined as throwing and es and throwing objects). chavior (defined as refusals and leaving facility property staff]). ded as hitting, slapping, and throwing objects). ded as biting self causing skin self causing skin damage and at #2's BIP did not contain any to his one-to-one staffing Administrator stated during an 0 from 1:05 - 1:50 p.m., -to-one supervision of incorporated into his BIP. Definition of the property of the propert	W 2	289	W 312 483.450(e)(2) DRUG US Preferred Community Homes he		
	client's individual p specifically toward elimination of the t are employed. This STANDARD	as an integral part of the program plan that is directed is the reduction of and eventual pehaviors for which the drugs is not met as evidenced by:			meetings for all individuals on 9. An experienced QMRP was sent home to coordinate the IPP meet During individual #3's meeting t medication reduction plan was re and the use of Risperidone and C were incorporated into his plan.	/28/10. to the tings. the eviewed	
	1	eview and staff interviews, it e facility failed to ensure		!			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	13G057	B. WING			C 6/201 0
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HO		6	REET ADDRESS, CITY, STATE, ZIP C 15 SECOND AVENUE WEST VENDELL, ID 83355		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
comprehensive par was directed specificand eventual eliminal which the drugs we individuals (Individual reduction plans was individual receiving without plans that is how they may char regression. The first 1. Individual #3's 2/year old male whose profound mental results Physician's Ordinal hereceived Rispermage ach evening a drug) 80 mg each evening a lindividual #3's Pareduction Plan, da criteria for reduction The reduction critereducing when [Individual #3] come here, put har me a hug, put arms around, jump, throughout a kiss, turn or the music, give me [Individual #3] will is one step directions 80% of trials per mi months."	drugs were used only as a rt of an individual's IPP that fically towards the reduction of nation of the behaviors for the employed for 1 of 3 and #3) whose medication is reviewed. This resulted in an a behavior modifying drugs dentified the drugs usage and the individual indindividual individual individual individual individual individual	W 312	A new Administrator/QM hired and assigned to worl Courtyard Facility. Her fi 10/13/10. The new Admireceive training from curred Administrative staff inclusimportance of assuring the medications are incorporately. The Assistant to the Region Administrator has been as provide supervision to the ICF/MR. He will spend a four days per month in the completing Quality Assurt to assure that compliance regulations is maintained. The Quality Assurance medications, IPP's and B that all needs are properly into each plan. The Admirmediately be notified if are found so corrective actaken. After the program has displayed a clear under the Quality Assurance Probe assisting with Quality measures. Person Responsible: To Assistant to the Regional Completion Date: 10/20	k at the irst day will be nistrator will ent ding the at all ted into the conal ssigned to e Courtyard a minimum of e Wendell area rance measures with One part of easures with IP's to verify y incorporated inistrator will f discrepancies etion can be a Administrator erstanding of ocess, she will Assurance m Moss, Administrator	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SU COMPLÉ	TED
		13G057	B. WI	1G			C 6/ 2010
	ROVIDER OR SUPPLIER	OMES - COURTYARD		61	ET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WES T E NDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 312	"should further incr follow instructions a However, a second dated 8/24/10, for 0 "continue to assist maladaptive behav The reduction crite direction was not c Informed Consents Risperidone and ur behaviors for Geod	ease [Individual #3's] ability to and increase his time on task." If Written Informed Consent, Geodon stated the drug was to [Individual #3] in controlling his iors." ria of following a one step onsistent with the Written (i.e., time on task for indefined maladaptive don). ecord documented he engaged going maladaptive behaviors: 6 280 280 280 280 287 280 298 200 200 200 200 200 200	W	312			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		13G057	A. BUILDING B. WING		00/	C 16/2010
NAME OF F	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP C		10/2010
		OMES - COURTYARD	615	SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX : TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 312	Continued From p - Dropping to grou 8/3/10 - 8/22/10:	•	W 312			1
	- Slaps = 3 - Attempts to hit = - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = - Dropping to grou	342			,	
	objective for follow was tied to his cor- contain objectives maladaptive behar	al #3's IPP contained an ving one step instructions which inmunication needs, but did not related to his ongoing vior, as noted above. w on 9/16/10 from 1:05 - 1:50	:			:
	p.m., the Administ behavior modifying maladaptive beha Individual #3's Psy	rator stated Individual #3's g drugs were prescribed for his viors. The Administrator stated vchotropic Medication seded to be revised.	:			
W 313			W 313	W 313 483.450(e)(3) DR	UG USAGE	
	must not be used narmful effects of	ntrol of inappropriate behavior until it can be justified that the the behavior clearly outweigh mful effects of the drugs.		Preferred Community Hor IPP meeting for individual experienced QMRP was shome to coordinate the IP During the meeting individual	I #3. An ent to the P meeting.	
	Based on record redetermined the fa	is not met as evidenced by: eview and staff interview, it was cility failed to ensure behavior were not used until the severity		behavior needs were discu plans were revised to inclu current needs including pl reducing individual #3's n	ussed and their ude their an for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		13G057	B. WII	NG		1	C 6/2010
	PROVIDER OR SUPPLIER	OMES - COURTYARD	'	61	EET ADDRESS, CITY, STATE, ZIP CODE 15 SECOND AVENUE WEST /ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 313	of the behavior was associated risks of (Individual #3) who were reviewed. The receiving behavior necessary justificated. 1. Individual #3's 2/year old male whose profound mental results of the profound mental profound for the profound mental profound in the profound profound in the profound mental profound in the profound mental profound in the profound mental profound in the	s shown to outweigh the the drugs for 1 of 3 individuals se restrictive interventions is resulted in an individual modifying drugs without the tion. The findings include: 16/10 IPP stated he was a 12 se diagnoses included tardation, ADHD, and autism. Sician's Order, dated 8/2010, ceived Risperidone (an 3 mg each evening and ychotic drug) 80 mg each Iritten Informed Consent for 8/24/10, stated the drug ease [Individual #3's] ability to and increase his time on task." Drug Handbook stated the side one included, but were not a (restless legs), somnolence, gical movement disorder), a, agitation, anxiety, pain, nors), suicide attempt, allucination, mania, impaired formal thinking and dreaming, sia, fatigue, depression, rocardia (rapid heart rate), chest potension (blood pressure ng), peripheral edema, hypertension, rhinitis (runny aryngitis, abnormal vision, ear ons, nausea, vomiting, creased saliva, diarrhea, e, increased urination, weight	W	313	Currently Individual #3's psych medications are being reviewed PCH office as part of the psych instead of a private physician. Changes can be monitored and i be taken from all team members a medication being implemente. A new Administrator/QMRP has hired and assigned to work at the Courtyard Facility. Her first da 10/13/10. The new Administrative receive training from current Administrative staff including the importance of assuring that the effects clearly outweigh the beam edication changes before mediate implemented. The Assistant to the Regional Administrator has been assigned provide supervision to the Court ICF/MR. He will spend a minimal four days per month in the Went completing Quality Assurance to assure that compliance with regulations is maintained. One the Quality Assurance measures includes assuring that the benefit medications clearly outweigh the harmful effects of the drugs for residents. The Administrator with mediately be notified if discreare found so corrective action contaken. After the program Administrator with Quality Assurance Process, be assisting with Quality Assurance.	at the clinic This way input can sprior to d. as been ne sy will be tor will the harmful nefits of dications d to styard mum of ndell area measures part of sets of the stall will repancies can be inistrator ding of she will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		13G057	B. WII	۷G			C 6/2010
	ROVIDER OR SUPPLIER	DMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		0/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	" '	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	OULD BE	(X5) COMPLETION DATE
W 313	gain or loss, hyperginfection. Individual #3's recovered evidence that his in remain on task out effects of Risperido b. A Written Inform Geodon stated the [Individual #3] in complete the gradient of the Property of the Nursing 2011 effects for Geodon to, dizziness, head attempt, akathisia, (involuntary muscle (muscle contracture energy), dystonia, a cogwheel rigidity (femuscles), paresthe disorder, psychosis QT interval prolong electrical activity of individual at risk for orthostatic hypoten hypertension (high abnormal vision, na (indigestion), diarrh hemorrhage, vomit sugar), and rash. During the entrance 3:00 p.m., the previous production of the previous	and upper respiratory and did not contain documented ability to follow instructions or weighed the potentially harmful one. ed Consent, dated 8/24/10, for drug was to "continue to assist ontrolling his maladaptive ver, the consent did not define viors." Individual #3's record on was ordered on 8/23/10. Drug Handbook stated the side included, but were not limited ache, somnolence, suicide extrapyramidal symptoms emovements), hypertonia e), asthenia (weakness, lack of anxiety, insomnia, agitation, erking motions of the joints and esia (numbness), personality s, bradycardia (slow heart rate), lation (an irregularity of the the heart that places an reentricular arrhythmias),	W:	313	Person Responsible: Tom Mos Assistant to the Regional Admir Completion Date: 10/20/10		
	as he did not exhib	it maladaptive behaviors.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI				
		13G057	B. WIN			09/16	5/2010
	OVIDER OR SUPPLIER	DMES - COURTYARD		61	EET ADDRESS, CITY, STATE, ZIP CODE 5 SECOND AVENUE WEST ENDELL, ID 83355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	objectives related to behaviors." Individual #3's reconvidence that the hunidentified malada assessed to determ potentially harmful its use. During an interview p.m., the Administry documentation that effects of Individual outweighed the potentially failed to Risperidone and Grisks of the behaviore.	ual #3's IPP did not include or "controlling his maladaptive or "controlling his maladaptive or "controlling his maladaptive or "controlling his maladaptive or did not contain documented armful effects of his aptive behaviors had been nine if they outweighed the effects of the Geodon prior to or 9/16/10 from 1:05 - 1:50 ator stated there was no accould show the harmful I #3's maladaptive behaviors tential risks of the drugs age those behaviors. In ensure Individual #3's ecodon were used only after the ors for which they were early shown to outweigh the	W	313			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057		B. WING		C 09/16/2010
NAME OF PROVIDER OR SUPPLIER	130007	STREET ADD	PRESS, CITY, S	TATÉ, ZIP CODE	09/10/2010
PREFERRED COMMUNITY H	OMES - COURTY/		ND AVENUE , ID 83355	WEST	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRÉCEDED BY SC IDENTIFYING INFORMA	FULL	ID PREF1X TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
Care. The resident participate in his participate in his participate of alternatives of alternatives are avalant considered in resident may requirepresentation and person of his choice and treatment.	evelopment of Plan of the Development of Plan of the must have the opposition of care. Residents live courses or care as a consequences when allable. The resident alternatives must be educiding on the plan lest, and must be entited assistance by any compared in the planning of the education of	an of rtunity to s must be ind n such s elicited of care. A tled to, onsenting	MM164	OCT	
Restraint Protection from At Restraints. Each restraints. Each restraints except with physician for a specific physician	net as evidenced by:	ed ne facility ysical ysical riting by a , or when the	MM177	MM177 16.03.11.075.09 PROTECTION FROM ABURESTRAINT Please refer to the plan of corr given for W122, W127 and W	ection
resident mobility for must comply with resident's behavio	c) Last Resort must not be used to or the convenience of life safety requirement r is such that it will re- others and any form	f staff, and nts. If a esult in	MM191	MM191 16.03.11.075.09(c) RESORT Please refer to plan of corrects for W278 and W313.	:

Bureau of Facility Standards

LATTRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	13G057	B. WING	09/16/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - COURTY/

615 SECOND AVENUE WEST

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
л М191	Continued From page 1 physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278 and W313.	MM191		
	16.03.11.075,10(b) Developed and Reviewed Has been developed and reviewed by a qualified mental retardation professional; and This Rule is not met as evidenced by: Refer to W289. 16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by:	MM195	MM195 16.03.11.075.10(b) DEVELOPED AND REVIEWED Please refer to plan of correction given for W289. MM197 16.03.11.075.10(d) WRITTEN PLANS Please refer to plan of correction given for W312.	
MM209	Refer to W312. 16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	MM209 16.03.11.075.15 RIGHT TO PERSONAL ITEMS Please refer to plan of correction given for W137.	

Bureau of Facility Standards STATE FORM

Bureau of Facility Standards				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
_	13G057		B. WING	09/16/2010
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE, ZIP CODE	
PREFERRED COMMUNITY HO	OMES - COURTY/	615 SECON WENDELL.	ID AVENUE WEST ID 83355	

PREFERRED COMMUNITY HOMES - COURTY/	WENDELL,	ID 83355		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIENCY PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM212 Continued From page 2		MM212		:
MM212 16.03.11.075.17(a) Maximize Developr ! Potential	mental	MM212	MM212 16.03.11.075.17(a) MAXIMIZE DEVELOPMENTAL POTENTIAL	
The treatment, services, and habilitation resident must be designed to maximize developmental potential of the resident be provided in the setting that is least rof the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	e the and must estrictive		Please refer to plan of correction given for W266.	
All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were properly stored under lock and key for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an environmental review on 9/14/10 from 6:50 - 8:00 a.m., the following toxic chemicals were found to be unlocked: a. In the laundry room: - Two 1.5 gallon bottles of Clorox Bleach. - 1 Bottle Great Value Glass Cleaner. - 1 can of Sprayway Glass Cleaner. - 1 plastic spray bottle labeled "Clorox with soap." - 1 spray bottle of Clorox Clean Up with Bleach. Two 2 quart bottles of Clorox Clean Up with Bleach.		MM271	MM271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS The facility has been inspected and currently all chemicals are labeled and under lock and key. Training will be provided to all employees on the regulation and all staff will ensure all chemicals are properly labeled and locked. In addition, the program Administrator will be assigned to do monthly inspections of the facility. One part of the inspection includes the Administrator looking for any chemicals not labeled or kept under lock and key. In the event that any chemicals are located that are not labeled or under lock and key, immediate corrective action will occur. Person Responsible: Tom Moss, Assistant to the Regional Administrator Completion Date: 10/20/10	
b. Under the kitchen sink: - 1 can of Sprayway Glass Cleaner.				!

PRINTED: 09/29/2010

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 13G057 09/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 615 SECOND AVENUE WEST PREFERRED COMMUNITY HOMES - COURTY/ WENDELL, ID 83355 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID. PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) MM271; Continued From page 3 MM271 1 plastic spray bottle of Windex Glass Cleaner. 1 plastic spray bottle of Western Family Antibacterial Cleaner with a masking tape label that stated "Fabreeze." c. In the garage where individuals bicycles were stored: One 2 gallon bottle Total Kill Weed and Grass Killer. - One 1.5 gallon bottle of Clorox Bleach.

1 bottle of Ferti-lome Root Stimulator.
1 bottle of STP Power Steering Fluid.
1 bottle of Western Family BBQ Lighter Fluid.

1 can of WD-40.

potto of trootoff talling bba digito. Flata.

1 can of Spectracide Wasp and Hornet Killer.
1 bottle of Western Family Anit-Freeze.
3 bottles of Inspecta Shield Fire Retardant.

The MSDS (Material Safety Data Sheet) for Clorox Clean Up with Bleach stated the product could irritate skin, eyes, nose, throat, and lungs, and was harmful if swallowed.

The MSDS for Great Value Glass Cleaner and Windex Glass Cleaner stated harmful if swallowed, could cause eye irritation, and could cause irritation if inhaled.

The MSDS for Sprayway Glass Cleaner stated the product was classified as a "Hazardous Chemical" and was harmful to skin, kidneys, blood, and liver.

The MSDS for Fabreeze stated the product was harmful if inhaled or ingested.

The MSDS for Total Kill Weed and Grass Killer stated the product was harmful if ingested, and caused eye and skin irritation.

Bureau of Facility Standards

PRINTED: 09/29/2010 FORM APPROVED

Bureau	of Facility Standards					FORIVI	AFFROVED
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	ETED
		13G057				09/1	6/2010
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
PREFER	RED COMMUNITY H	OMES - COURTY!		ND AVENU -, ID 83355	E WEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
MM271	Continued From pa	age 4		MM271			
	The MSDS for WD harmful if inhaled o	-40 stated the productor swallowed.	ct was				
		ectracide Wasp and Fooduct was harmful if ind skin irritation.					
		stern Family Anit-Fre was harmful or fatale					s .
		pecta Shield Fire Retowas harmfu! if swallowad eye irritation.					
		ti-lome Root Stimulat armful if swallowed, a e irritation.					
		Power Steering Flu armful if swallowed, a e irritation.					
	stated the product lung irritation, was	stern Family BBQ Lig could cause eye, ski harmful if swallowed y, brain, and nerve da	n, and , and				
	was present during #6 was known to p	ervice Coordinator (R g the review, stated In lace items in his mou emicals should have	ndividual uth. The				

Bureau of Facility Standards

Repeat deficiency

The facility failed to ensure all toxic chemicals were maintained under locked conditions.

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING С B. WING _ 13G057 09/16/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - COURTY/

615 SECOND AVENUE WEST

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETS DATE
	Continued From page 5	MM620		:
MM620 16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W193 and W249.			MM620 16.03.11.230.05(b) UPGRADING OF COMPETENCIES Please refer to plan of correction given for W193 and W249.	
MM725	16.03.11.270.01(b) QMRP	MM725	MM725 16.03.11.270.01(b) QMRP	i
	The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.		Please refer to plan of correction given for W159.	
MM726	16.03.11.270.01(c) Individual Resident Treatment Plan In addition to the participation of the IDT, the individual resident treatment plan will be developed with the participation of: This Rule is not met as evidenced by: Refer to W207.	MM726	MM726 16.03.11.270.01(c) INDIVIDUAL RESIDENT TREATMENT PLAN Please refer to plan of correction given for W207.	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	MM729 16.03.11.270.01(d) TREATMENT PLAN OBJECTIVES Please refer to plan of correction given for W227.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING С B. WING 13G057 09/16/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - COURTY/

615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES .	ID	PROVIDER'S PLAN OF CORRECTION (X5)
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MM729 : i	Continued From page 6	MM729	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 16.03.11.270.01(d)(i) DIAGNOSTIC AND PROGNOSTIC DATA Please refer to plan of correction given for W214.
MM731	M731 16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237.		MM731 16.03.11.270.01(d) MEASURABLE BEHAVIORAL TERMS Please refer to plan of correction given for W237.
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239.	MM855	MM855 16.03.11.270.08(c) TRAINING AND HABILITATION RECORD Please refer to plan of correction given for W239.
	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861	MM861 16.03.11.270.08(f)(iii) PERIODIC REVIEW Please refer to plan of correction given for W260.

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Bureau of Facility Standards STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING C B. WING _ 13G057 09/16/2010

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MM861	Continued From page 7		MM861		
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